The Components of Satisfaction with Care during Labour in Hong Kong Chinese Women: Qualitative Study

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A Thesis Submitted in Partial Fulfilment

Of the Requirements for the Degree of

Master of Philosophy

in

Nursing

December 2000

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Acknowledgements

I wish to thank my supervisor, Professor Valerie Levy, Associate Professor of Department of Nursing, Faculty of Medicine, the Chinese University of Hong Kong, for her guidance, kindness and scholarship. Professor Levy gave me the chance to have in-depth understanding of qualitative research approach and interview skill. I also thank for her critical review and giving precious opinion to my thesis.

I acknowledge the support from the Central Nursing Division of the Queen Elizabeth Hospital for the permission to conduct the research. I would like to thank for Dr. H.K.Wong, Chief of Service & Ms. Sharon Ng, Department Operational Manager, Obstetric & Gynaecological Department, QEH for the approval and facilitation to conduct the research. I also thank to the staff of Obstetric & Gynaecological Department and Ambulatory Care Centre for their excellent assistance and support.

I am so grateful to Ms. Mary Driedger, Clinical Nurse Specialist, Health Sciences Centre, Women's Hospital, Manitoba, for sending the last copy of her master thesis " Partpartum women's perception of satisfaction with childbirth" to me. Hence, I could have deeper understanding about women satisfaction with childbirth.

I would like to express my sincere thanks to my husband. Without his fully support, understanding and encouragement, this thesis cannot be possible. Finally, I cannot against all odd to finish my three years master course without their full support and encouragement.

Abstract

A qualitative study was conducted to explore the labour satisfaction of Hong Kong Chinese women in a public hospital. Fourteen post-partum women with different educational and socio-economic backgrounds were recruited by means of purposive sampling. In-depth interviews were conducted to explore the components of satisfaction with the care provided during labour. The method of content analysis was used to analyze the interview data. Most participants mentioned the phrases "felt secure" and "a sense of security" when asking them about the components of satisfaction with care. That suggested the components of women's satisfaction during labour contribute to fulfil their need for a "sense of security" and this became the central theme. Six categories emerged from the data. Components of satisfaction during labour were organized under the central theme of "sense of security". The six categories were identified as companionship, information and guidance support, competence and attitudes of the caregivers, physical comfort, outcome of labour as well as environment and facilities. The findings were compared with the relevant literature. Consensus and differences were identified. "Companionship" had meanings shared by both Chinese women and Western women. All women needed somebody they trusted to stay with them during labour. Further, Chinese in general tend to obey the professionals. Women trusted the professionals to a large extent. A trusting relationship between women and health caregivers was found to be crucial in building up some components of satisfaction, which were information support, pain management and competence and attitudes of the caregivers. Women also appreciated competent health

caregivers with caring attitudes. Providing "encouragement" and "praise" could act as an activator to reinforce the inner strength of the women, protecting and restoring their dignity and face during labour. In the area of physical care, Hong Kong Chinese women focused on the care provided in which to maintain the equilibrium of Yin-yang and avoid "cold" and effective pain management. Women also gained a sense of security by looking at their newborns, confirming the health of the babies. Environment and facilities could also contribute to the sense of security such as the design of the birthing bed. Implications for midwifery practice, education and further research were discussed in the light of these findings.

研究摘要

本研究為探討香港婦女對產科護理的滿意成份。 經立意取樣方法，邀請了十四位教育程度、社會及經濟背景不同的香港中國產後婦女作深入的訪問，及採用會談指引。再用內容分析，找出能令婦女產生時對護理感到滿意的成份。研究結果顯示出大多數的受訪婦女被問關於護理服務時，她們都會提到“安心”、“放心”或“安全感”等詞彙。 這正表示婦女能感滿意是建基於“安心”或“安全感”上。經過歸類內容分析找出“安心”為核心成份及其他六個成份。 換言之，若婦女能安心地生產嬰孩就能令她們滿意。然而，各成份就構成使婦女生產時感到有安全感。 這六個成份包括陪伴、資訊及指導的支援、工作人員的能力及態度、身體的舒適、生產結果、環境及設施。 與其他同類的研究作比較，如“陪伴”就與西方的研究有一致結果，有丈夫或助產士陪伴在側，產婦就會感到安心及滿意。在資訊方面，中國人普遍都會服從專業人士，而產婦亦十分相信專業人士的知識及指導。因此婦女與醫護人員的互信關係亦能影響建立滿意的成份，包括資訊及指導的支援、工作人員的能力及態度、疼痛處理。在生產時，給適當的鼓勵及

讚賞都能使產婦發揮她們內在的能力去應付壓力及困難。而身體舒適方面，她們會注重於避免著涼以保持冷暖平衡(陰陽調和)及疼痛的處理。而生產後立刻給產婦看看她們的初生嬰孩，她們就會倍感安心，知道自己的孩子健康正常。而環境及設施亦能影響產婦的安全感，例如產床的設計是否安全。論文中亦包括對研究結果作出有關產科的臨床應用、教育及進一步科研的提議。

~ CHAPTER ONE ~

INTRODUCTION

Background

Health care professionals involved in maternity care have a common goal during labour -- the birth of a healthy baby by a healthy mother (Simkin, 1992). Apart from this common goal, both health care professionals and women view labour differently resulting from different expectations and different perceptions of achievement and satisfaction (Churchill, 1995). Health care professionals tend to concentrate the achievement in terms of low perinatal and maternal mortality rates, or 'technical ability' (Bond and Thomas, 1992; Churchill, 1995). Meanwhile, pregnant women view childbirth not only as a biological process but also as a special event of their lives and the fulfilment of their expectations (Churchill, 1995).

Labour is a physiological process leading to the birth of a baby. Labour also is a highly individual experience, perceived differently by individual woman. Although labour usually occurs over several hours or within a day, it produces a great impact on women. Studies (Simkin, 1991 & 1992) showed that the memories of their first birth were retained accurately by the women for decades, and the birth experience could produce permanent or long-term positive or negative consequences, for example, regarding women's relationships with their

babies and their partners. Thus labour is an important life experience for a woman.

In Hong Kong, maternal and infant mortality rates are very low. Maternal and infant mortality rate are 1.5 per 100,000 delivery and 3.2 per 1,000 delivery respectively (Hong Kong Government, 1999). To a certain extent, this means living standards, general health as well as the maternity care in Hong Kong are of a very high standard. However, the mortality and morbidity rates are only so called objective outcomes of health care service. They cannot reflect the complete picture of the quality of care provided in Hong Kong. Therefore, it is a good time to move the focus of concern to the subjective outcomes of health care – women's satisfaction in maternity care (Lomas, Dore, Enkin & Mitchell, 1987).

Indeed health care service is undergoing tremendous change in Hong Kong, in term of its structure and the increasing expectation of consumers within the past decade, following the establishment of the Hospital Authority. Health care providers are also increasingly expected to be more client-oriented. In recent years, more and more people are concerned about the consumer aspect regarding the health care service (Lo, 1998). Thus customer satisfaction or patient perception are now considered as an important aspect of quality of care in Hong Kong. This implies that health care professionals should be more aware of the

consumers' opinions. Health care professionals are highly self-regulated to improve clinical standards. Health care providers must not only maintain the highest clinical outcome but also must deliver a service that satisfies the clients (Krowinskin & Steiber, 1996.) Therefore care providers must have full understanding of what constitutes both clinical excellence and client satisfaction in order to meet the dual challenges. Exploration of patient satisfaction level can indicate different perspectives of care we deliver (Bond & Thomas, 1992).

Many studies have been conducted to find out how satisfied women are with maternity care and the relationship between satisfaction and variables such as participation in the decision-making, expectations, information received, sense of self-control and interventions (Field, 1978; Green, Coupland & Kitzinger, 1990; Brown & Lumley, 1994; Seguin, Therrien, Champagne and Larouch, 1989.) Those studies have provided rich information by means of both quantitative & qualitative method in the Western countries. However, little is known in this aspect in the Chinese culture. There is evidence that patient satisfaction relates to patient expectations. Meanwhile women's expectation regarding childbirth also varies from one culture to another (Callister, 1995). In order to enable exploration in depth of issues such as satisfaction, expectations within a cultural context in relate to women experiences of labour, a qualitative research study was conducted in Hong Kong.

Maternity Care Practice in Hong Kong

In Hong Kong, pregnant women either attend clinics of private obstetricians or that run by the Government during the antenatal period. As pregnancy carries on, they will decide in which hospitals they are going to deliver their babies. There are nine public and ten private hospitals with delivery suites serving a population of seven million. There are around fifty thousand deliveries per year. The public hospitals account for seventy percentage of the total delivery (Hospital Authority, 2000). Almost invariably, women deliver their babies in hospital and the practice of home confinement is virtually unknown in Hong Kong. Midwifery practice at present largely follows a medical model of obstetric care. Midwives attend approximately about sixty-five percentage of birth in the public hospital setting (Hospital Authority, 2000). Ambulation in labour is discouraged. Women are asked to remain in bed after the membrane is ruptured. Episiotomy is the routine practice for all first and second vaginal delivery in public hospitals. Women usually deliver in lithotomy position. Women will be discharged from hospital about three days after normal delivery.

Purpose of the Study

The aim of the study is to explore and describe Hong Kong Chinese women's experience of childbirth in order to identify the components of satisfaction during labour.

Significance of the Study

Through the use of in-depth interviews with women after labour, their perceptions of what constituted satisfaction with the birth experience were explored. In this thesis, an attempt is made to yield a better understanding of labour experience of Chinese women in Hong Kong.

Organization of the Thesis

This thesis is organized into five chapters. Chapters one presents the introduction, maternity care practice in Hong Kong, the purpose of the study, and significance of the study. Chapter two presents a literature review on the aspects of patient and consumer satisfaction, and satisfaction with childbirth. Chapter three describes the research methodology of the study. In chapter four, the findings and discussion of the study are presented. In chapter five, the summary of the findings is presented, and implications for midwifery practice, education, and further research recommendations are discussed in the light of the findings.

~ CHAPTER TWO ~

LITERATURE REVIEW

Introduction

Traditionally, mortality and morbidity rates are the important indicators to reflect the standard of the health care service. Fitzpatrick (1993) argued that it was narrow scoped just to focus on the mortality and morbidity. These could not reflect the complete picture of the quality of care provided. Patient satisfaction is strongly interrelated with quality of care provided and acts as a good indicator to serve the purpose of outcome measure (Krowinskin & Steiber, 1996). Therefore, it is a good time to move the focus of our concern to the subjective outcomes of health care – women's satisfaction in maternity care (Lomas et al, 1987).

Fitzpatrick (1993) stated that patient satisfaction involves a cognitive evaluation and emotional reaction towards the health care service provided. Patient satisfaction is a complicated phenomenon linked to patient expectation, health status and personal characteristics as well as to the health care system. There is no consensus on the definition of patient satisfaction (Bond and Thomas, 1992). In this chapter various aspects of patient satisfaction are discussed. A literature review is presented on various concepts relating to patient satisfaction, the importance of the labour experience in women's lives as well as approaches to assessing women's satisfaction with care during labour.

In this study, the literature was searched by means of electronic reference: MEDLINE and CINAHL. Keywords including "satisfaction", "birth" and "labour" were entered to search the relevant English literature from the year of 1980 to 2000. By reading through the abstract of the articles in the MEDLINE and CINAHL, relevant articles were searched for the full text in the university library. Those articles not available in the local libraries were obtained by overseas inter-library loan. At the same time, those keyword "patient satisfaction", "birth" and "labour" were entered into the electronic library searching system to seek for the relevant textbooks available in the university library. After reading through all related full texts of journal articles and textbooks, their key references were sought for full text again. By the snow ball reaction, the relevant and useful articles were sought to form the literature review of this thesis.

Conceptual Theories of Patient Satisfaction

Many studies have examined aspects of patient satisfaction in general and several of them have relevance to women's satisfaction with care during labour as follows.

In Pascoe's contrast model, Pascoe (1983) described that patients enter the health care setting with their own expectation towards the health care services.

Satisfaction equates to the difference between real experience and expectation. This means that patient feel satisfied when their health care experience exceeds their expectation. Conversely, patient are not satisfied when their health care experience fall behind their expectations.

According to Pascoe's theory, women with high expectation will be the ones easily disappointed. However, a study about expectation, experience and psychological outcomes of childbirth (Green et al, 1990) revealed low satisfaction was associated with low expectation. Hence, the relationship between satisfaction and expectation was not as simple as Pascoe described. The contrast model of Pascoe may be too simplistic to explain client satisfaction (Bramada & Driedger, 1993).

Linder-Pelz (1982) developed ten attributes in her literature review of patient satisfaction. Linder-Pelz proposed that patient satisfaction must be understood within a context in which some components may be more or less satisfying to the patient. The ten attributes included accessibility, availability, resources, continuity of care, efficacy, finance, humanness, information gathering, information giving, pleasantness of surroundings and quality. Based on the ten attributes, Linder-Pelz also developed a set of standardized questions, SERVQUAL, which has been used in many services sectors (Krowinskin & Steriber, 1996).

Strasser & Davis (1991) developed a model of patient satisfaction. The model consisted of two parts (refer to Figure 1). Four components were used to build up the model, which included stimuli, value judgement, reaction and individual differences. In part 1, they defined patient satisfaction as patient's value judgement and subsequent reactions to the stimuli they perceive in the health care environment. In part 2, the definition focused on how people' dispositional make up, personality, need structure, values, beliefs, personal life and previous health care experience can modify and shape our responses to these stimuli. Thus, these value judgements and reactions will be affected by the characteristics of the patients and their past experiences about the health care system.

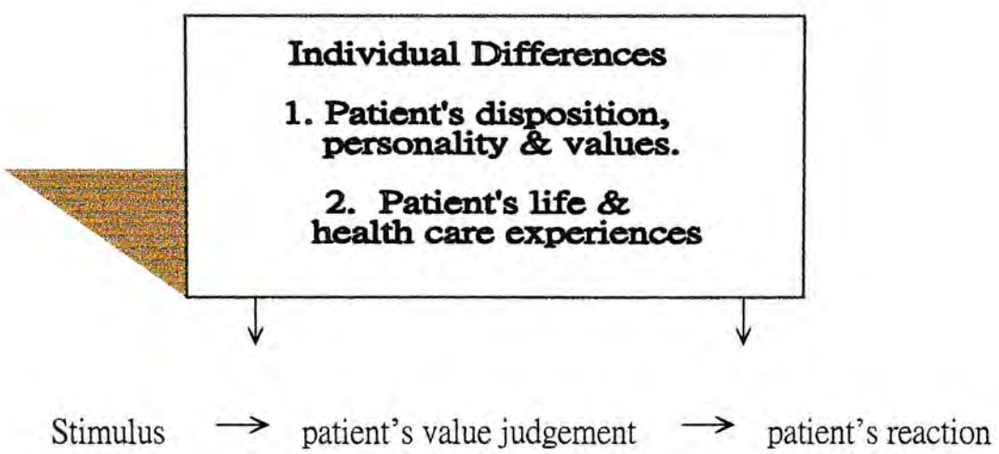

Figure 1 : A Definition of Patient Satisfaction and the Patient Satisfaction Process.

(Strasser & Davis, 1991, p.55.)

These theories describe patient satisfaction in the health care system in broad and general terms and are frequently applied in the context of hospital administration and consumer's satisfaction with products and service. However, these theories or models may be too simplistic to totally explain client satisfaction (Bramadat & Driedger, 1993). Patient satisfaction has been frequently measured. Diversity of the theoretical and conceptual frameworks of patient satisfaction are documented (Bond & Thomas, 1992; Staniszewska & Ahmed, 1999). Quantitative measures cannot explore every possibility and are devised from the etic view, or service providers rather than the emic, or consumers' view.

The Importance of Labour Experience in a Woman's Life

After nine months of pregnancy, labour becomes the climax of the whole journey of childbearing. Childbirth or labour usually occurs within a single day. However, childbirth is a major event in a woman's life (Kitzinger, 1978; Crouch & Manderson, 1993). Simkin (1992) describes that "The birth of a child, especially a first child, represents a landmark event in the lives of all involved. For the mother particularly, childbirth exerts profound physical, mental, emotional and social effect" (p.64). Labour is not merely a physiological and mechanical process. Labour is a transition stage of life from pregnancy, the woman becoming a mother of a child. Labour is not only the end of the pregnancy but also the beginning of the parenthood of a family (Crouch & Manderson, 1993).

Simkin (1991 & 1992), compared long-term and short-term memory of childbirth of first birth experiences and showed that women's memories were vivid with deep emotion and long-lasting even 15 to 20 years after childbirth.

Not only are childbirth experiences long-lasting, they may be also powerful. Both good and bad memories are vivid, accurate and deeply emotional. Women can express deep appreciation even 15 to 20 years later for kind words and actions they received. They may also express their anger and hostility over perceived cruel things that caregivers said and did for them many years ago (Simkin, 1991 &1992).

Hofmer, Nikodem, Wolman, Chalmers and Krame (1991) conducted a study to explore the psychological responses and perception of women towards companionship during labour. Supported women reported that they felt themselves coping well during labour. They suggested that the positive labour experience might reinforce the women's self-esteem and confidence during labour. Those supported women also stated that they felt competent and confident in adapting to parenthood and initiating successful breastfeeding. Thus, the study demonstrated that a good experience of childbirth could deeply affect the mothers as well as their babies.

The positive childbirth experience can also enhance the women's confidence and competence in the early parenthood (Hofmer et al, 1991). On the other hand, a negative childbirth experience may cause impact to the women and their family members as follows. Some case studies have provided evidence that some women experienced "Post traumatic stress disorder" (PTSD) after childbirth (Lyons, 1998). Women with PTSD were suffering from prolonged nightmare following childbirth. Women feared the process of labour and they avoided pregnancy. O' Driscoll (1994) reported in a case study that one woman had been unable to make love since the birth of her daughter eighteen months previously. Moreover, Ballard, Stanley and Brockington (1995) reported four cases of PTSD following childbirth and each mother had problems responding to her baby. Those case studies illustrated that these women did not want to take care of their infants in order to avoid triggering the vivid memories of previous traumatic delivery.

Both positive and negative childbirth experiences do produce great impacts on women and their family members (Hofmer et al, 1991; Lyons, 1998). Apart from the safe outcome of healthy mother and healthy baby, Simkin (1996) advocated that the joyful experience of the childbirth is an important woman's life event. Oakley (1993) also stated that " what they [women] want is both a healthy baby and a good experience – the two being two sides of the same coins – not opposed but complementary to one another." (p.106). Thus women's satisfaction should be an important indicator of the quality of care provided during labour.

Studies about Women Satisfaction during Childbirth

Field (1987) conducted a qualitative research study to examine parents' satisfaction with maternity care in labour in Canada. The result showed that satisfaction increased when the parents felt they were respected, kept informed of the progress and procedure by the caregiver. Moreover, the competence of the caregiver also could give parents a feeling of security and much more confidence. Meanwhile, the environment only acted as an influencing element in relation to satisfaction when the caregivers had been created a positive atmosphere.

Green, Coupland and Kitzinger (1990) conducted a study to determine women's expectation of childbirth in the United Kingdom. Women were invited to completed three questionnaires, two before the birth and one six weeks after birth in order to find its importance and its relevance to psychological outcomes of childbirth. While four different indicators of psychological outcomes were considered: fulfilment, satisfaction, emotional well-being and the words that women used to describe their babies. By using factor analysis, four groups of satisfaction were identified as follows: satisfaction with decision-making concerning major interventions, satisfaction with coping with pain, satisfaction with decision concerning minor interventions and satisfaction with staff care. Meanwhile the survey also found that the women's sense of control in their labour was related to positive emotional outcomes during post-natal period. Having high expectations

did not necessarily lead to feelings of failure and dissatisfaction; on the contrary, expectations were relevant to outcomes at all it was women with low expectations who were more likely to have poor psychological outcomes.

Seguin, Therrien, Champangne & Larouche (1989) also conducted a study about the components of women's satisfaction with maternity care in Canada. They carried out the study by mean of 84-items questionnaires to evaluate the several dimensions of satisfaction with childbirth. By factor analysis, 5 components of satisfaction were identified. They consisted of the delivery itself, medical care, nursing care, information received and participation in the decision-making process and physical aspects of the labour and delivery room.

A survey was conducted to measure the satisfaction with care of 790 women during labour and birth in Australia (Brown & Lumley, 1994). The result showed that access to information during labour, relationships to caregivers, the extent of involvement of decisions making about their care, exposure to inventions were the components of satisfaction with care.

Bluff and Holloway (1994) conducted a qualitative study to examine the women perception about midwifery care during labour. They found that a great deal of trust of midwives was expressed by women. This research illustrated women trusted midwives because midwives were seen as the experts who 'know

best' about the labour. The women and their partners believed in the knowledge and competence of the midwives. Thus women would like to hand over the authority to professionals to make decision about procedures, drugs and type of care during labour. It demonstrated that importance of a trusting relationship between women in labour and their midwives.

A randomised controlled trial involving 1299 women was conducted in the United Kingdom about satisfaction with midwife-managed care in different time periods (Shield et al, 1998). In midwife-managed group, women were allocated a named midwife who aimed to provide the majority of planned antenatal and postnatal care. The result showed that women in both groups were satisfied. However, women in the midwife-managed group were more highly satisfied in relation to the different aspects: relationships with staff, information transfer, choices and decision and social support.

Many research studies were conducted to examine obstetrical patient satisfaction in the Western countries in the previous two decades. A literature review (Murray, Wilcock & Kobayashi, 1996) concluded that patient satisfaction in maternity care included presence of support person, information support, sense of control, participation in decision making, nursing care as well as physical environment. All these research studies contribute to build up the empirical knowledge about women's satisfaction with care.

Cultural Influence to the Woman Satisfaction

Sheila Kitzinger (1978) stated that childbirth like many other physiological process such as drinking, eating, maturity, old age and dying are culturally defined, and reflect social values. She also stated that "human childbirth is a cultural act in which spontaneous physiological process operates within a context of customs, the performance of which is considered essential or desirable for a safe outcome." (Kitzinger, 1978, p.105).

Many studies have been conducted to find out the satisfaction level of women about maternity care and the relationship of satisfaction with the variables such as participation in decision-making, expectations, information, interventions during labour, relationship with the caregivers and being respected (Field, 1987; Green et al, 1990; Brown & Lumley, 1994; Seguin et al, 1989). Those studies have been provided rich information by means of both qualitative and quantitative method in the Western countries. However, little is known in this aspect in the Chinese culture. If women's satisfaction relates to women's expectations, components of satisfaction and expectations will also vary from one culture to another (Callister, 1995).

Leininger (1991) describes the basis for culture care as "Care is the essence of nursing and the central, dominant and unifying focus of

nursing"(p.35). Leininger also states that culture is seen as the blueprint for living. Birth, aging, illness, survival and death are experiences within a cultural frame of reference. Nursing care must be congruent with the individual's culture care values and needs. With this specific knowledge, midwives can provide culturally congruent caring which can be beneficial to their clients.

A study was conducted in Hong Kong about Chinese women's perception of support from midwives during labour (Holroyd, Lee, Wong, Yau & Leung, 1996). In Hong Kong, 98% of population is Chinese. The Bryanton Adapation of Nursing Support in Labour Questionnaire (BANSILQ) in Chinese version was used to examine the issue in the Chinese culture of Hong Kong women. The category of informational support with specific behaviour of "praise me" was regarded as the most supportive by the Chinese women in Hong Kong. "Touching" was considered the least helpful behaviour in the study which demonstrated a cultural difference regarding midwives support. At the same time, the social behaviours of Chinese people were strongly influenced by the philosophy of Confucianism and Taoism, which were quite different from the Western culture (Leininger, 1995; Yang, 1987). Confucianism is regarded as a philosophy of humanity and a guide to living of the people. Confucius believed that the harmonious human relationships could facilitate enhance of social order and harmony. Confucius concentrated on three perspectives to conserve a balance: the individual, the family and the country. Those were the so-called

Five Cardinal Relations, including these relationships between sovereign and subject, father and son, elder brother and younger brother, husband and wife, friend and friends (Bond & Hwang, 1986). In each case, the senior members had a wide range of privilege over the juniors. Since Chinese people have a strong sense of filial piety and authoritarian attitudes, they generally tend to be obedient, humble and patient. Traditionally, patients also take a passive role to obey the health care professionals as the authority (Leininger, 1995; Bond & Hwang, 1986).

Taoism is also another important philosophy deeply influencing the Chinese people. It emphasizes the inner strength, balance, selflessness and harmony with nature and human being. Taoism also includes the yin-yang theory (cold-hot theory). The yang is represented by the male, the heaven and hot, whereas the female, the earth and cold, represents the yin. Yang and yin forces are important in all interactions for good care practice and health. In the belief of Taoism, it is important to maintain good health, harmonious living and happiness through the life. To maintain the yin-yang balance, all aspects of living avoid going to the extreme such as rest and work, drinking and food as well as emotion (Leininger, 1995). Consequently, the Chinese culture possesses its unique features, which are different from the Western culture as mentioned above.

As Kitzinger (1978) stated, childbirth like other physical processes such as eating is culturally defined. All human being need to eat to survive. But different ethnic groups eat differently and cook differently or may place different emphasis on aspects of labour. Research into components of satisfaction in labour have been conducted primarily in Western cultures. Thus, there is the need to conduct qualitative research to provide a richer picture of Chinese women's experience in labour (Holroyd et al, 1996).

Measuring Women's Satisfaction in Labour

There are no standardized questionnaires with well-established validity and reliability to assess the satisfaction level of women during labour because of a lack of universally agreed definition (Shearer, 1987; Bond & Thomas, 1992; Stanisewska & Ahmed, 1999). Hence, different instruments have been used to measure patient satisfaction depending on the situation. Measuring satisfaction level of patient is regard as a method for health care consumers to express their need and opinion (Fitzpatrick, 1990). At the same time, it also reflects the subjective outcome of care.

Shearer (1987) argued that asking women to rate their satisfaction with care on a single scale might lead to underestimation of their dissatisfaction. Dissatisfaction cannot be reflected effectively in an overall satisfaction scale. Thus it would be unwise to use an overall measure of satisfaction as an indicator of the quality of maternity care provision. It is necessary to examine the factors that give women a positive experience of childbirth (Hundley, Milne, Glazener & Mollison, 1997).

Hence, this research study is conducted using a qualitative approach to investigate the components of satisfaction with care during labour by using in-depth interviews. The use of this qualitative approach ensures that the research focuses on the perspective of the participants. It is a so-called emic approach, which studies the topic from the participants' point of view (Pontin & Webb, 1996; Rubin & Rubin, 1995). Through these interviews with women after labour, their perceptions of what constitutes satisfaction with the birth experience are explored.

Conclusion

In this chapter, the literature about women's satisfaction during labour is discussed. Objective outcomes of maternity care, such as mortality and morbidity rates of mother and baby are important indicators of the service provided. Subjective outcomes of maternity care, can also provide impact greatly on the women experiencing childbirth. Due to diversity of the definition of patient satisfaction, there is no fixed and unique method to measure patient satisfaction in the clinical setting. Many studies have been conducted to explore women's satisfaction in maternity care, using both qualitative and quantitative methods. Rich information has emerged from those studies about the factors contributing to women's satisfaction during labour in the Western countries. A wide ranges of factors contributing to satisfaction have been identified, including presence of support person, information support, participation in decision making, control, nursing care as well as physical environment. Kitzinger (1978) emphasized that the childbirth experience is related to the clients' cultural values. Leininger (1995) advocated that nurses should provide care which must be congruent with the individual's cultural values and need. However, literature about this issue in Chinese culture is scarce. Holroyd et al (1996) who have conducted a quantitative research about midwife support in Hong Kong also suggested it is necessary to explore in detail this issue in Chinese culture. Therefore, a qualitative approach was selected to explore the components of satisfaction during labour in Hong Kong Chinese women from an emic perspective.

~ CHAPTER THREE ~

RESEARCH METHODOLOGY

Research Design

The methodological difficulties of measuring woman satisfaction towards maternity care are well documented because satisfaction is a complex emotional and psychological response to events. Many women have difficulty verbalizing what they mean when they say they are "satisfied" (Bramadat & Driedger, 1993; Brown et al, 1994.) Some studies (Brown & Lumley, 1994; Seguin et al, 1989 ; Slade et al, 1993) attempted to define and measure components of satisfaction with care during labour. However, these studies were conducted by using a quantitative approach to measure the satisfaction level by means of questionnaires. Bramadat & Driedger (1993) argued that satisfaction is multidimensional and people's response might not be accurately measured by an overall satisfaction scales. Thus it may be misleading to use a single measure of overall satisfaction. At the same time, there is little knowledge about patient satisfaction during labour in Hong Kong Chinese culture. Qualitative approaches are particularly directed towards exploring and describing phenomena that have not been studied before (Ziebland & Wright, 1997). In order to gain in-depth understanding about women's labour experience about labour, it is therefore appropriate to conduct a qualitative research study to explore this aspect locally. Therefore, a qualitative

research design was used in this research. Rather than having preconceived ideas about the important factors, this exploratory study could encourage participants to identify, describe and explain which aspect they viewed as significant components of satisfaction during labour. A qualitative approach by in-depth interview to assess patient satisfaction can provide appropriate strategies for gaining access to patient's opinions and concerns (Pontin & Webb, 1996; Ersser, 1996). Clients can set agendas that are relevant to them rather than being asked about issues deemed important by staff (Rubin & Rubin, 1995).

Qualitative interviews are particularly useful when exploratory work is necessary. It may be premature to carry out a patient satisfaction survey without sufficient relevant information about local situation upon which to construct valid questionnaires (Ersser, 1996). Thus qualitative interviews were considered to be the best way to elicit the perceptions of the clients in this local situation.

The Setting

The study was conducted in a public acute general hospital in Hong Kong with various specialties where the author worked. This hospital is the biggest hospital in Hong Kong with about 1,850 beds. This regional hospital has one of the highest delivery rates in Hong Kong, more than four thousand babies being born there in 1999.

The Sampling

Before the stage of data collection, the author met with midwives of obstetric clinic and post-natal ward of the hospital where the study would be conducted in order to discuss criteria for selecting participants of the study. Staff was encouraged to refer potential subjects to the author. Meanwhile, the author tried to contact some post-natal women by telephone from the general roster in order to invite them to join the study. Although thousands of women gave birth in this hospital during the stage of data collection, not much women were willing to spend time to discuss their labour experiences and some of them said they had no comments to the care provided during labour.

Fourteen Hong Kong Chinese women were invited to join the research. Those women had undergone labour and had delivered a healthy baby at term. Both primiparous and multiparous women were included. Participants were recruited with different educational and socio-economic backgrounds in order to obtain variability in the samples. Meanwhile, purposive sampling also implied that researcher selected participants on the basis of personal judgment (Polit & Hungler, 1995). Participants were selected by means of purposive sampling. Participants were not only just those who had gone through the journey of labour, but those who were willing and able to share and discuss their experience of labour.

Data Collection

Data Collection Procedure

Data collection was conducted from February 1999 to October 1999. Data were collected through in-depth ethnographic interviews by the author. To ensure the accuracy and completeness of the data, interviews were tape-recorded with the participants' permission. Participants were contacted by telephone to arrange interviews at a convenient place and time.

Twelve face-to-face interviews were conducted either in the women's home or the author's office according to the women's preference. Face-to-face individual interview was a desirable form of interview in this study. Author could react and notice the non-verbal response of the participants such as facial expression and gesture during interview. Two participants were willing to join the study but it was convenient for them to have face-to-face interview in author's office. Meanwhile, they also felt uneasy to conduct interview at their homes. After considering their situation, two telephone interviews were conducted on these two participants' requests. Those telephone interviews were recorded by using the "speak-out phone" function of the telephone. Although the author could not get the non-verbal cue from the telephone interview, the progress of interviews ran smoothly.

On average, the interviews lasted for about forty-five to seventy minutes. Interviews were not conducted in the maternity ward because women usually stayed in the ward for three to four days after a normal delivery. Furthermore, they often felt very tired just after delivery. It was thought they might find it difficult to be honest about the care they received if they were still hospitalized (Seguin et al, 1989). They were totally absorbed by the care of their newborn babies. During this time may be difficult for them to discuss unpleasant and experiences that they had had during delivery. Therefore, the interviews were carried out after the women had returned home, approximately four to twelve weeks after delivery. Then, they were likely to be less tired, and at ease to voice out their feelings while their memory of the experience was still fresh.

The author was responsible for data collection, transcription, and analysis of data in order to ensure the consistency, accuracy of data processing.

Data Collection Method

An individual interview approach was used in this study and guided by an interview schedule. The in-depth interviewing was to elicit the participants' perspective, without imposing the points of view of the researcher.

Ethnographic interview was used to guide the approach and framework of the interview. The use of an ethnographic interview was particularly cultural relevant to explore the components of satisfaction from the emic perspective (Morse & Field, 1995). According to Sorrell and Redmond's explanation (1995), an ethnographic interview includes three stylistic elements.

1. Explicit purpose:

   The interviewer must state the purpose of the interview to participants at the beginning of conversation.

2. Ethnographic explanations:

   The explanation to the participant shifts from general questions to more specific areas in the topic such as " I'm interested in hearing something that made you feel satisfied during labour".

3. Ethnographic questioning:

   Descriptive, structural and contrast questions will be used to get information. The author explained their purpose and nature before starting the interview. Ethnographic questioning includes descriptive, structural and contrast questions such as: -

   "Could you tell me something about your labour experience?"

   " Could you describe how you felt during labour?"

"What was your labour like?"

" How satisfied do you feel with the care you received during labour?"

" What made you feel satisfied \ dissatisfied with your labour?"

Demographic data were obtained by filling the demographic sheet (see Appendix A) from each participant including age, level of education, occupation, parity, mode of delivery and the baby's condition at birth. Those data were collected and verified with the hospital record to enable crosscheck validity, and to facilitate the identification of possible links between participants' backgrounds and their perceptions of labour.

Field notes (see Appendix B) was used to record some information about interviews in written form, for example, starting time and ending time of the interviews in order to count the length of time of interviews taken place. Non-verbal behaviours, the author's impression just after the interviews were also included in the field note to remind the author what had happened during interviews in which to facilitate the analysis later. And it can act as an aid in keeping track of data and locating related interviews (Morse & Field, 1995).

Fourteen interviews were conducted in the study. An interview schedule was used to ensure that all topics were covered. The approach of a 'focused interview' however allowed question to be asked in any order, probing their ideas or

not specifically asked if the topic arose spontaneously. Although the schedule was used in this way, women were encouraged to tell the story of their labour (Mishler, 1986).

Interview Schedule

Interview schedule (see Appendix C) comprises a checklist of questions used during interviews. The interview schedule of this study consisted of ethnographic interview questions as mentioned before and probing questions. The interview schedule could facilitate the researcher to focus the discussion on the phenomenon of interest (Ree, 1997). The advantages of probing questions were that they could allow participants to refine and elaborate their meanings in the relevant issues. At the same time, the author could explore and clarify inconsistency and ambiguity with participants. The interview schedule had been evaluated by the author's supervisor, an expert in qualitative research and a local registered midwife. The content validity of the questions was checked in order to ensure that the questions were really inquiring what the study was intended to investigate, the components of satisfaction during labour.

Data Management Technique

Interviews were conducted in Cantonese, a dialect spoken by most of the people of Hong Kong. Interviews were translated into English. English transcription could facilitate the author to discuss with the English-speaking research supervisor; thus it allowed better supervision throughout the process of analysis. Due to the difference of grammar in Chinese and English language, the author tried to translate the interviews in a way to maintain the original meaning of the women's narratives as accurately as possible. Although the analysis was undertaken by the English transcripts, the author listened to each audio-tape several times to become familiar with the data. The original Chinese wordings used by women were directly translated to the English synonyms. This way some sentences may seem awkward to English readers. To overcome this difficulty, elaboration were put in quotation immediately after those 'awkward sentences'. The translation of the interviews was conducted by the author. Some quotations were then cross-checked for consistency by other bilingual Hong Kong Chinese midwives. The quotations finally were then checked by an English-speaking person for syntactical accuracy.

Interviews were transcribed as soon as possible after the interview by the author. The author was responsible for transcribing and translating the interviews in order to maintain the consistency of translation (Twinn, 1997). The author had

fresh memory of context and non-verbal communication, thus could accurately describe the response of the participants in the transcription and make appropriate analysis on it (Morse, 1991).

Data Analysis

Data analysis in qualitative research means breaking down the narrative data and searching for codes and categories which are then reconstructed and combined to form themes. Data analysis took place from the beginning of data collection. The process of data collection and analysis in qualitative research was a cycle (Porter, 1989). Thus, the author looked for the consistent patterns of data and categories during the process of data collection. As a qualitative study, there were about one hundred and fifty sheets of narrative data for analysis. Therefore, it was essential to use a systematic approach in the study. The transcriptions were analyzed by means of content analysis in this study.

Definition of Content Analysis

Content analysis is a method of qualitative data analysis to handle the narrative data in the study sorting out to different categories. Each interview is segmented by these topics into categories (Morse & Field, 1995).

In this study, latent content analysis was used. Latent content analysis is "a search for meanings in the data which are not immediately obvious from listening and reading. The analysis goes beyond surface theme and appearances to underlying phenomena and their interpretation." (Holloway, 1997, p.35). Thus paragraphs were reviewed in the background of the whole interview in order to code the relevant sector.

Steps Involved in Content Analysis

There are 3 basic steps for a content analysis:

1. Making decision what unit of analysis will be.
2. Developing the set of categories
3. Developing the rationale and illustration to guide the coding of data into categories (Wilson, 1989).

Firstly, a decision was made on what units of analysis would be used, whether to use a whole response or to break down responses into separate words, phrases or sentence. When conducting content analysis, the author had to read the entire interview transcription again and again in order to identify several important

cues to search the relevant data. Therefore, the words meaning "satisfaction", for example, " I liked ..." , " It is nice ...", " It is good ..." , " I'm happy with ..." were sought in the transcript. And the words meaning dissatisfaction, for example, "I don't like that..." and "I was dissatisfy..." were sorted out. Those negative instances would be arranged into the related categories.

Those units of analysis were sorted out from the transcription. At the same time, data were coded according to their meaning of the sentence. For example the code "encouragement " was given to the response as the follows:-

" I was exhausted... I wanted to give up and not to push. I also begged for vacuum (vacuum extraction delivery). However, they encouraged me and said, "You can! You can do it!" That made me feel that they were very supportive. So that I was quite satisfied." (Participant 6)

Therefore a group of data was sorted out from different interviews and was put under a category with similar meaning. Positive and negative comments about the same issue were put also into a same category for a complete picture for this topic (Strasser & Davis, 1991).

Secondly, the set of categories was developed. Once the data were coded, they were read thoroughly again to search for similarities and were grouped together

into categories. The data with similar codings were cut up and pasted onto cards forming the categories of the study. Those similar sub-categories were put under a category. For example, the codes "encouragement", "delicate care", would be put into the category of the "competency and attitude of the staff". The codes such as "teaching", "coaching" and "guidance" would be put into the category of the "information support"

Thirdly, the definition and illustrations were established to guide coding of data into categories. In this step, the author had to make a judgement on the right categories for every response or unit of analysis (Wilson, 1989).

The data were managed by manual method of coding. Usually the main theme was labelled within each paragraph by writing the code in the margins. The labelled paragraphs were cut and pasted onto a large sheet of paper for manual sorting. The relevant phrases or sentences were highlighted for assisting in grouping that portion of text into common collection in the next stage of data analysis (Morse & Field, 1995).

To summarize, the content of each transcript was analysed by coding. Codes were grouped to form categories. Six major categories emerged from this study.

Trustworthiness and Credibility of the Study

The purpose of qualitative research is not to objectify and to test theory, but rather to gain understanding of the participant's experience (Sandelowski, 1986). In qualitative research, different areas of the study including the design of the study, sampling, data collection method, process of data analysis and the credibility of the researcher herself/himself also contribute to build up the trustworthiness and credibility of the study (Mackenzie, 1994; Morse & Field, 1995).

Sampling

The trustworthiness of data in this study could be ensured by careful selection in sampling in people, place as well as time (Morse and Field, 1995).

In this study, a purposive sampling method was used to select the participants. By means of purposive sampling, the participants had experience of labour and were willing to discuss and examine their experiences. The researcher used her personal judgement to select who was the suitable or right person, for example, in selecting those participants who could and would give their own first hand experience about labour to the researcher. Fourteen participants were recruited in the study. They had heterogeneous backgrounds (please refer to the Appendix D for detail description) and provided rich information and different perspectives to the study thus enabling variability across the sample. This could

ensure the data collected was in-depth and broad enough for forming categories of the study.

Data Collection Method

a. The interview schedule

By using interview schedule, it could ensure that all participants were asked with same set of questions. Thus it could help to maintain the consistency of questions and all questions covered including probing questions. At the same time, through the focused interview, participants were encouraged to speak out their own story of labour. Focused interview encourage a dialogue and atmosphere between interviewer and interviewee conducive to deep explanation of the issues arising (Mishler, 1986). Other midwives validated the content of interview schedule. Thus the trustworthiness of the study could be enhanced.

b. Data Collection: Time & Place

The choice of place and time of to collect data also affect the trustworthiness of the women's satisfaction study. Women might find it difficult to be honest about the care they received if they were still hospitalized (Seguin et al, 1989). In the study, the interviews were conducted after women were discharged home. The participants chose the place they liked for the interviews. The author's office or their own homes was an option.

The month of confinement after delivery is very important to women in the Chinese culture. Within the month of the confinement, women have to take rest and avoid going outside so as to restore their body strength after childbirth. Therefore, the interviews were arranged after the month of confinement. Simkin (1991 & 1992) found that women's memories about childbirth were retained accurately for decades. In this study, participants were interviewed several months after childbirth when was assumed that the memory of labour should be still vivid.

Credibility of the Researcher as the Instrument in the Study

The credibility of the study can be increased if the research was carried out in an environment and culture familiar to the researcher (Brink, 1991). I was the researcher in the study. I am a nurse midwife who has been working in the hospital for several years. Prior to my present work, I worked in the delivery suite of the hospital, the place where the subjects of this research were selected. Thus I had good knowledge of the settings and operation of the delivery suite. This enhances my credibility as an investigator. The fact that I am now not working in the delivery suite is yet another advantage. I would not feel offended by harsh comments nor feel flattered by appreciation from the participants. Women would also feel at ease to voice out any dissatisfaction knowing that I was not part of the delivery suite. Hence, the bias of the findings could be minimized during the stage of data collection and analysis (Marray et al, 1996).

Increasing credibility of data analysis by discussing

Throughout whole process of the study especially on the areas such as research methodology, data analysis, interpretation of data and forming categories, the author discussed with her supervisor and other Chinese midwives in Hong Kong to seek for second opinion in order to minimize the bias whilst maximising scope for interpretation. For example, I had analysed an interview about a participant who was given blankets to keep warm. At first, I intended to code the phrase as "cold environment" or "caring behaviours of midwives". My supervisor suggested that it might be related to the traditional Chinese concepts about "cold" after delivery. After that, two more participants mentioned the same point about "cold". Therefore, I suggested that "provide blankets to keep warm" could also relate to the Yin-yang theory.

Ethical Issues of the Study

Official Approval for the Study

Approvals were obtained from the Ethics Committee of the Chinese University of Hong Kong and the regional public hospital (Appendix E & F). Furthermore, the letter of approval was also granted from the Chief of Service, the Department of Obstetric and Gynaecology where the research was conducted (Appendix G).

Confidentiality

The author transcribed all audio-taped interviews herself. The audio-tapes were erased after the completion of the research study. The participants were asked not to mention names during the interview. Any names that appeared in the interviews were deleted or replaced by a code. Coded numbers were used to label audiotapes and transcripts in order to maintained confidentiality of the data. For example "P6" represented the sixth participant in the study. This way, confidentiality of the participants was protected. Demographic data of the participants and the audio-tapes were stored separately. Accessibility to the transcripts was restricted to the author and her supervisor. Demographic data of participants is only presented collectively term. Therefore, the participants could not been identified.

Informed Consent

The rights of the participants were safeguarded by obtaining informed consent. Verbal and written explanations of the study were given to each participant individually before interview. Consent form was obtained from each participant (See Appendix H). Each participant had the right to accept or refuse the invitation to participate in the study and could withdraw from the study at any time. The participants in this study were provided with a written information sheet (See

Appendix I). They could contact the author by telephone whenever they had any question about the study.

Handling Complaint from Participants

As the role of the researcher, I tried to be a good listener in the research study. If any complaints or dissatisfaction were voiced by participants towards the maternity service, I decided to stand neutral and make no judgement and comments on either party (Polit & Hungler, 1995). Only giving information regarding how they could make an official complaint if this is what they wanted. Although dissatisfaction and complaints emerged from the interviews, no participant decided to make a formal complaint through the appropriate channel such as the patient relations officer of the hospital. To certain extent, it implied that their dissatisfaction was not great enough lead to formal complaint although they may have been other additional reasons for not complaining. Participants were willing to join the study in order to express their feeling towards labour. In fact, all participants said they were pleased to have the opportunity to share their experiences. The participants were very eager to share their feeling about labour experience to me. They also expected that their opinion about satisfaction and dissatisfaction could be reflected to the related department of the hospital to improve the quality of service, and I agreed to this.

Conclusion

In this chapter, the research methodology has been described in detail. Ethical issues are also included. Fourteen participants were selected from a public hospital in Hong Kong and interviewed on the components of satisfaction during labour.

~ CHAPTER FOUR ~

FINDINGS AND DISCUSSION OF THE STUDY

In this chapter, findings of the study are presented, supported by quoting the transcription of the interviews. For clarity of presentation, findings and discussion of the study are kept together. In the beginning, demographic information of the participants is described. In subsequent part of the chapter, findings that appeared from the interviews are described. Components of satisfaction during labour are organized under the main theme of "Sense of security". Sense of security was identified as the core component of satisfaction with care in Hong Kong Chinese women to which all the other components in the framework contributed. These components of satisfaction consist of companionship, information and guidance support, competence and attitudes of the caregivers, physical comfort, outcome of labour as well as environment and facilities. In the following pages components of satisfaction will be described one by one in detail.

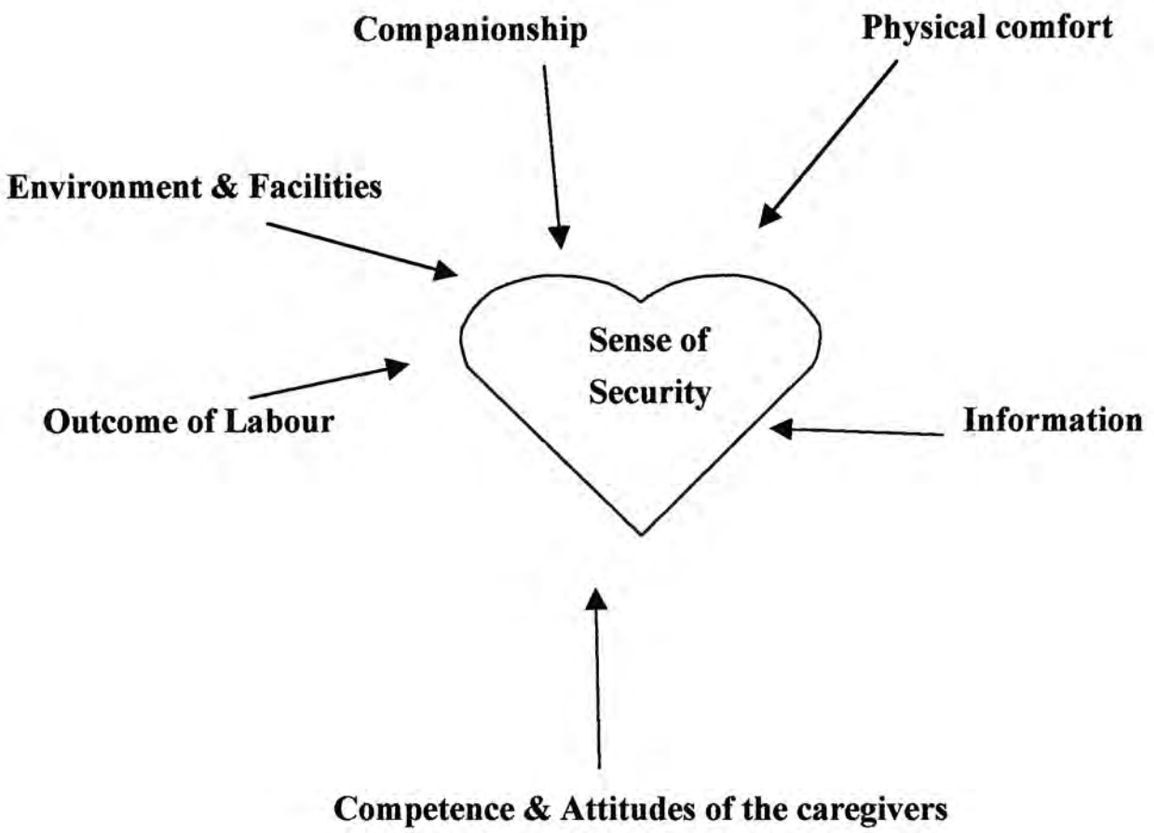

Figure 2:

Components of Patient Satisfaction during labour with care during Labour

(Core Component: Sense of security)

Demographic Information of the Participants

The sample consisted of fourteen women who had given birth at this public hospital in 1999. Nine of the women were primiparous, three delivered their second baby, and two delivered their third baby. Participants were between 23 to 36 years of age from a range of social backgrounds. All of them were married. They had upper secondary school or university education level. Nine of the women had normal vaginal deliveries. One of them had a vacuum extraction delivery. Three had emergency caesarean sections because of prolonged labour or no progress of labour. Eight had their husbands accompanying them. Eight had epidural analgesia during labour. All babies were full-term and healthy at birth (Apgar score of eight or above at 5 minutes after delivery and no gross abnormality).

The Author's Experience about Interviews

Before as a master student, I only had an experience as a research assistant to conduct interviews when I was an undergraduate student. Therefore, before the stage of data collection of this study, I interviewed my friends who had delivered babies for practicing the interview skills such as using pause, avoiding leading questions. Those interviewees gave comments to me for improving the content of the interview schedule such as wordings of the questions.

Sense of Security:

Core Component of Women's Satisfaction with Care during Labour

In this study, all participants said they were pleased to be interviewed about the issue of labour satisfaction. They were informed about the topic of the study before interview was taken place. Although I had contacted participants beforehand for the arrangement of interview, I was still a "stranger" to them. Some of them found it difficult to start the conversation about the topic of satisfaction with care during labour. Therefore, I would like to ask something about their babies such as feeding in order to warm them up for the interview as well as to establish a friendly relationship. After five to ten minutes of chattering, I could re-focus the conversation to the study. Then I would ask the questions according to the interview schedule and they were encourage to start the interview by telling their stories about labour.

When asking something about satisfaction with care during labour to the participants, they seldom used the phrase " I was satisfied..." . They would like to describe their experience of labour in detail and started with the phrase " It was nice...", " I was delighted..." , at the end of the dialogue they said that " I felt secure." . On the other hand, they described dissatisfaction by using the direct wordings that " I was dissatisfied with..." . The word " felt secure" frequently occurred in the interviews (interviews 4, 5, 6, 7, 9, 12 & 14). Half of the

participants had mentioned the word "secure". The word "secure" in Chinese character is "安心". Within the Chinese belief system, the heart is seen as the centre of all and wills, good and bad, mind and emotion, originating from there (Leininger, 1995). The word "心" means the heart. The word "安" means safe, secure, stable or in peace. The Oxford English dictionary (1982) defines the word "secure" or "security" meaning safe and safety, free from danger or anxiety and peace of mind. The sense of security means a person is in a state free from physical and psychological dangers. The word "satisfaction" means giving somebody what they need and want (Oxford, 1982). Women feel satisfied when they feel free from physical and psychological dangers. Women's emotions were at peace during labour so that the women described this kind of feeling as "安心".

In the early stage of analysis, sense of security was categorized as one of the components of satisfaction with care during labour. After going through content of all classified components of satisfaction again, it was found that all those components had a common goal to be achieved: increasing sense of security of women's innermost feeling. The components of women satisfaction during labour contributed to fulfill the women's need of "sense of security" in this thesis (Refer to Figure 2). Hence the idea of "sense of security" was extracted out from the pool of components of satisfaction. "Sense of security" was highlighted and arranged as the central theme of the findings of this study. For example, women were satisfied when either their husbands or midwives stayed with them. With their presence,

women could feel secure. Taking another example, midwives provided information to women about what had happened to them. Women wanted to obtain information not for decision-making but only to feel peace of mind.

Today, with advanced obstetric care, maternal and neonatal mortality has been reduced tremendously. Our collective social expectations have received knowledge and message concerning the trends in this regard. Thus, the public does not expect complications in pregnancy and childbirth (Crouch & Manderson, 1993). Pregnant mothers also expect normal outcomes of labour for both mothers and babies. On the other hand, as a matter of fact, complications in labour do occur and mishaps can not be totally eliminated or always be foreseen accurately. Hence, modern technologies are not reassuring enough. Fear of death and damages occurring in labour do subsist at the back of women's mind (Detsch, 1983; Mackey, 1990). Particularly in Chinese culture, traditionally Chinese believe strongly that labour is a highly risky process. There is a saying in Chinese that going through labour is just like standing at the door of hell. There is a dilemma between expectations and facts about labour.

Besides fear of death and damage in labour, studies have identified other aspects of fear occurred in labour. Up to this new millenium, fear in labour described in the literature could be broadly categorized into five themes: fear of childbirth as pain, the unknown and unpredictable, death, feeling of being unsafe and lack of trust as well as loss of control (Lindsjö and Petra 2000). Faced with

such fears and threats in labour, it is not surprising that women in this study were concerned about sense of security. It appeared that by building a sense of security they could evade fears of labour. In this study, six components of satisfaction during labour were identified and are linked to the sense of security in childbirth.

As far as labour satisfaction is concerned, a sense of security has been scarcely described in the literature. A phenomenological study (Halldorsdottir & Karlsdottir, 1996) about the childbirth experience of women in Iceland reported that the need of a sense of security could be fulfiled by the presence of a caring midwife, who provided guidance, information and the progress of labour to women during the labour journey, and by the presence of partner. Field (1987) found that sense of security was one of the needs of parents during labour. A local study (Holroyd et al, 1996) also reported that provision of sense of security was perceived by Hong Kong Chinese women as the fifth important item of midwives support during labour.

In this study, a sense of security was identified as the main concern of women in labour in Hong Kong. It is the core of women satisfaction in labour. Following section components of satisfaction will be presented and discussed one by one in detail.

The Components of Satisfaction with Care during Labour

1. Companionship

Hong Kong is a place with dense population, 1,070 square kilometer with about seven million people (Hong Kong, 1999). People can travel to a nearby regional public hospital or private hospital within a short distance. Therefore, nearly all deliveries take place in hospital. In hospital settings, health care personnel such as midwives or doctors will stay with women for labour. About ten years ago, the scheme of "Husband Accompany Labour" was introduced into the service of the public hospitals. Therefore, discussion of companionship in this study mainly focuses on the presence of husbands and midwives who accompany labouring women on their birth journey.

Companionship was identified as the first category contributing to a sense of security as well as satisfaction during labour. The presence of a support person or so-called "being there" was one of the most important elements reported by women in this study and others (Driedger, 1991; Marut & Mercer, 1979).

1.1. Husband as a Companion

In this study, 8 couples chose the " husband accompanying labour" scheme in the hospital. All these husbands had attended antenatal preparation classes

about labour beforehand. Those eight participants showed appreciation to their husbands for staying with them during the process of labour. Childbirth became an important life event to the women as well as their husbands. Women said they felt secure when their husband were there during labour.

"During painful moments, I felt comfort and secure when my husband was with me, even though he just held my hands and chatted with me." (Participant 12)

Two women also had similar experience and commented that:

"With his〔husband's〕presence in the labour room, it meant there was a close relative with me. Actually, he provided no help as far as my pushing was concerned. However, I felt secure when he was there." (Participant 14)

" Oh! It was really very helpful. I felt secure. When I was accompanied by my husband, I felt secure." (Participant 5)

Moreover, the couple had gone through the labour journey together. Therefore a woman commented that:

"My husband was quite sure what had happened to me and how much in pain

I was. If my husband only waited outside the labour room, he would know nothing except I had given birth to a baby and that was all. Accompanying delivery, he could hear other women and I screamed loudly. Oh! Uterine contraction was really very painful!" (Participant 5)

These husbands not only knew what had happened to their wives during labour but also became able to empathize with their wives for their suffering.

" For example, at least, he knew that it was a difficult task to give birth to a baby. I heard somebody said their husbands did not know how difficult labour would be. Those husbands do not understand their wives. But my husband said that he would tell my child that its mother suffered very much during delivery. He could step into my shoes to experience what I felt. " (Participant 8)

In fact, husbands had gone through the labour process both psychologically and physically with their labouring wives.

"At that moment 〔just after delivery〕, only my husband and I were in the room. I told my husband that I wanted to cry. Because we had been waiting for the birth of our baby for so long and I was so exhausted. My husband also told me that he also wanted to cry too. I asked him why? He said he had gone through a great event

in his life. I felt it was so touching. He told me that he seemed to have gone through a journey of labour by himself when I was in pain. When he told me to push, he also made an effort to push together." (Participant 10)

With their husbands' presence, women felt satisfied and secure psychologically. At the same time, women also treated their husbands as a helping hand when they were confined to the bed. Women would ask for help from their husbands' in particular aspect of care, for example, turning position and applying massage.

" He 〔husband〕 could help me turning to another side in the bed. Then I needed not call midwives for help. He helped me very much . . . For example, I felt numbness of my limbs, he applied massage to the affected part." (Participant 5)

" I told B 〔husband〕 to call them back. It would be a mess if B was not there. They were not aware of that because doctor had just performed breaking of membranes. They [midwives] had already gone. They said they would see me later. Then B called them back." (Participant 7)

" After having epidural analgesia, I felt numbness on my hands. He [husband] applied massage to my hands for many times. It was very helpful. I felt better." (Participant 10)

Although many participants acknowledged the importance of their husbands' presence and helping, not all husbands could play that role properly in the labour room. There were two first-time fathers trying their best to support their wives, but doing this in an inappropriate way. They seemed to be "over-energetic" when instead their wives expected them to remain calm.

The husband of Participant 6 did not know what to do when his wife was in great pain, so he frequently asked his wife what he could do for her. Husband's reaction made Participant 6 more irritated.

" My husband stayed with me, holding my hands and asked what he could do to me in order to help me. I was irritable and I did not even want to reply to his questions. I remembered that a midwife tried to calm me down and reassured me... They 〔midwives〕did not irritate me because they talked with me in a good attitude. On the other hand, maybe my husband felt helpless. He did not know how to help me and sometimes make it worse. He frequently asked me what I wanted. I did not remember what he said. I only felt he was so disturbing. Therefore, I neglected him. But he asked me once again. Thus, I felt more irritated. (Participant 6)

Participant 13 showed appreciation to her husband's support. She was exhausted and wanted to take a rest, but she did not know how to express the need to

her husband. The husband also was not aware that she was very tired.

"Chatting with him [husband] could make me feel less anxious and bored. Meanwhile, I hoped that he did not mind that I was falling asleep. But the labour process was so long, more than 10 hours, I also would like to let him take a rest." (Participant 13)

Although many couples chose to join the scheme of "husband accompany labour", some husbands were unwilling to attend birth of their babies.

"No, we didn't join the scheme. Because my husband refused that. Because of he attended antenatal classes about labour. He saw some slides showing pictures of women delivering babies. It was horrible! Thus he refused to join the programme." (Participant 3)

" I wanted him so (attending birth), but he did not accept it. It was because somebody said that it might affect the married life if husband attended birth. I have asked him before. He refused to do so. I let it be." (Participant 2)

From the findings of the study, the husband's presence during labour was a significant component of satisfaction. And it was evident that, for most

participants, practical support from their husbands was also an important element of the supporting system during labour. Over the past two decades, there has been a trend of increasing numbers of fathers attending the birth of their children in Western countries (Draper, 1997). In the early 1990s, the idea of "Husband Accompany Labour" was introduced to the public hospitals in Hong Kong and integrated as a part of maternity service to couples (Ip, 1997). In this study, women stated that they felt secure when their husbands stayed with them during labour. Husbands, as a labour companion, can increase the mothers' psychological well being. A research study (Thornton & Lilford, 1994) showed that the presence of a companion throughout the process of labour could reduce the rates of instrumental delivery and caesarean sections. In this study, the findings also showed that some women felt secure with husband staying together even though they came to terms of instrumental delivery or caesarean sections with different reasons. (See Appendix A)

Apart from the psychological well being of the women, husbands also were regarded as helping hand during labour by their wives while they were confined on the birth bed. In Hong Kong, ambulation in labour discouraged. The participants did feel free asking for help from their husbands rather than midwives, for example, massage and turning position. Women might feel uneasy to ask for help from midwives on these aspects of caring such as massage, which involved intimate body contact. Enkin, Keirse, Renfrew & Neilson (1995) ironically commented that the presence of husbands at birth can help to "fill the gaps in care": "Recognizing

that labouring women require psychological support and realizing that midwives and nurses have little time to give it, hospitals have increasing permitted and encouraged men to assume active role in the care of their partners during labour." (p.194). However, there was no evidence to support this statement that the purpose of encouraging fathers' attending birth is to solve the problem of shortage of manpower in the local situation. It did not mean that the midwives had handed over the duty of care to their husbands but women preferred their husbands to perform these kind of relieving measures. Moreover, a study (Holrody et al, 1996) found that Hong Kong Chinese women perceived "touching" was the least important midwifery support during labour. Bond (1991) explained that Chinese people use distance to regulate their privacy and level of intimacy in an encounter, with greater distances being observed in more formal gatherings. Thus Chinese people seldom touch others during conversation or hugging during greeting. It could reflect the Chinese culture treated body contact such as touching or hugging as an intimate body contact done by their spouses.

Besides the positive psychological outcome of the labouring women, husband also can benefit from this kind of experience. Although the feeling of fathers was not explored in this study, midwives should consider the father's experience of childbirth. Palkovitz (1987) tried to find out the reasons why they attended birth. Fathers expressed the reasons: being close to and supporting his labouring partner; to develop a bond with the baby; to express their loving feeling

towards the baby and to make it easier for the father to be involved in the daily care of the baby.

On the other hand, the presence of the husband at delivery was considered important but not a 'must' as this practice sometimes has its own shortcomings (Draper, 1996). In this study, some women also stated the reasons why their husbands did not like to attend the birth. In Chinese tradition, labour and menstrual fluid are regarded as unclean and taboo, men should be prohibited attending labour (Rabuzzi, 1994). Although, Hong Kong was a British colony for centuries, people are still deeply influenced by Chinese culture and it is held that labour is the woman's business. Midwives in Hong Kong should advocate the benefits of husband accompany labour to the public. At the same time, midwives could explore the reasons why husbands refuse to attend birth. Appropriate explanations should be provided in order to eliminate some misunderstanding and misconception about that such as midwives, however, should not pressurize husbands to attend birth. In fact, it is a personal judgement and some husbands may find it difficult to deal with the situation of their partner in pain and bleeding during labour as well as a taboo in the culture. A study (Vehviläinen-Julkunen & Liukkonen, 1998) found that some husbands felt discomfort during delivery. The causes of discomfort included fear, anxiety, helplessness, and worries about baby's welfare. Enkin et al (1995) also suggested that the father should not be expected to provide the majority of the support when he is also emotionally involved. In fact, he also may need

support from staff. Understandably, some participants' husbands were not willing to attend birth of their baby in this study.

For first-time fathers, the experience of birth may be overwhelming. Some were confused and uncertain of their role during labour process. Besides the welfare of the labouring women, midwives should pay attention to the men's experiences about childbirth (Draper, 1996). Thus midwife should teach the husband how to perform their role and duty during labour by mean of role modeling. Role modeling can help inexperienced and nervous husbands to find a worthwhile role in helping their labouring wives, for example, actively helping their wives during and after contractions with breathing and relaxation techniques as well as giving comfort measures (Hodnett, 1996). Consequently, husbands can know how to do, what to do and when to do in order to avoid making the condition worst as Participant 6' s husband. Although the husband had attended antenatal classes about labour, midwives should spend some time to talk with them when the woman was quite comfortable on their own. Husbands should be encouraged to voice out their needs and not forced to do more than he wants (Robertson, 1997).

1.2. Midwife as a Companion

Apart from the husband's companionship, the midwives were the health care professional spending a considerable time with women during labour. Women needed the midwives to stay with them, even though their husbands were present in the labour room.

" When my husband arrived, the midwives intended to leave us. However, I felt uneasy about that. Therefore, I insisted that midwives should stay with me. I obeyed the midwives' instruction rather than my husband. It was because my husband knew nothing about labour. Therefore, their [midwives] support was very important to me."

(Participant 14)

For those women without husbands' company, the midwives became the key people as a companion in the labour room.

" The midwives could instruct me what to do. They were as helpful as a close relative. Midwives were like my relatives. With their presence, I felt secure."

(Participant 4)

" At the nighttime, my husband was not there. Thus, support from midwives became significant to me. Although they were not always beside me, I was pleased that they attended upon me frequently. It was an important support to me."
(Participant 14)

" They(midwives)stood beside me. They did not leave me alone. They were quite nice. Although I did not know where they were, once I called for help, they turned up immediately... They stood beside me. They also stood beside me when I was in great pain." (Participant 9)

At the same time, midwives not only looked after women but also their husbands as well during labour.

"They [midwives] told my husband that whenever he needed help, just feel free to call them. They came to see me frequently, even though they were very busy." (Participant 5)

The word midwife means "with woman". Therefore, the important role of midwives is companionship. Participants emphasized that " They stood beside me", " they frequently attended me" and " they did not leave me alone'. With the

midwives presence, women felt secure. And they could feel that they were not alone and neglected during the difficult time of their lives. Driedger (1991) identified "Being there" was a theme of satisfaction during childbirth. Women desired to have somebody there whom they knew, loved and trusted. This finding was consistent with Koldjeski (1990) who described the professional nursing caring paradigm as "Being", "Relating" and "Doing". "Being there" or presence of the healthcare professionals was identified as one of the essences of caring. Through professional nursing care, the wholeness and integrity of a patient-centered approach was maintained.

Apart from the presence of husbands and midwives, it is the 'norm' for female relatives to be present during labouring in traditional Chinese culture. According to the findings, participants preferred midwives as their companion during labour in the hospital setting because midwives were female, knowledgeable and experienced in matter of childbirth.

Two participants commented about female relative to accompany labouring women. They also described their relationships with midwives as followings:

" We were very friendly to each other. They [midwives] were like my sisters."
(Participant 4)

" I wanted somebody who has experience in the matter of labour. . . Midwives instructed me what to do. They [midwives] were helpful and knowledgeable in the matter of labour. Midwives were just like my relatives. With their presence, I felt secure." (Participant 14)

It is well known that bonding among Chinese family members is intimate. Chinese people are strong influenced by Confucianism and believe that they have responsibility in taking care of family members and relatives, especially when others are encountering stressful event. Thus, it is common that post-natal women are taken care by their mothers, mothers-in-law or other female relatives during the month of confinement (Chang, 1995; Neile, 2000). According to the findings of this study, women preferred midwives stayed with them in a hospital setting because midwives were women and experienced in labour rather than their female relatives. Midwives were regarded as "close relatives" and "sister" by participants. Hence, the findings of this study demonstrated that when the husband and midwife stayed with the labouring women, women felt secure and satisfied. Although the scheme of husband attending labour become more and more popular in Hong Kong, the unique role of midwife as a labour companion cannot be replaced.

In conclusion, companionship is a universal component of satisfaction to both the Western and the Chinese women. All women need somebody they trusted

to stay with them during labour.

2. Information and Guidance Support

Many participants commented that teaching and guiding support was important to them. They said that they had no experience to handle labour situation especially for the first time mothers. In this study, nine participants were primiparous. Some of them did not attend antenatal classes. Only two claimed that they had completed whole course of antenatal education. So they may have some incomplete information or even wrong concepts about what would happen during labour (McIntosh, 1989). It is important to provide information such as breathing and relaxation exercise, what will happen during labour in order or to provide a sense of security to them.

A woman said that she was taught many things during labour:

"I was pleased that they taught me when to push, how to push, and how to breathe. That meant they taught me many things." (Participant 3)

Women pointed out the importance of the method of giving instruction during the second stage of labour. They stated that midwives demonstrated the bearing- down technique to them: -

"A midwife held my hand and taught me how to breathe. She took a deep breath with me together 〔relaxation exercise〕. Take a breath and relax, and take a breath again, she taught me to take a rest in between two contractions" (Participant 14)

Roberts & Woolley (1996) suggested encouragement to push during appropriate situation such as fully dilatation of cervix and involuntary bearing-down effect, and the appropriate method of instruction could be the most effective bear-down effort during second stage of labour.

" During labour. . . during labour, I felt that the midwife did not know how to guide me bearing down. . . Because the midwife wanted me to push alone by myself. But after half an hour, another midwife came and taught me once again how to use force for bearing down. She taught me to use downward force. She used a small wooden stick to touch my lower part [perineum] for illustration. Then I understood how to do it. I could really use my own force. Twenty minutes later, I gave birth to my baby by myself. That kind of guidance was O.K. The first midwife only asked me to push and push but didn't teach me how to do it properly. I did not know how to use my pushing force." (Participant 8)

Women were conscious during labour. Hence, information and clear

explanation must be provided to them when interventions were performed in order to gain their co-operation. The frequency of explanations provided delivery was the factor contributing to the women's satisfaction.

" I had difficulty lying laterally because I felt back pain. They explained to me the reason why I was asked to do so. They did not order me "Lie on your side" . But they explained to me that my baby's heart rate might not be detected unless I lay in a lateral position on the bed . . . I fully understood what they meant, then I could cooperate with them." (Participant 5)

Because of no progress of labour, this woman had to give birth to a baby by caesarean section with spinal anaesthesia. During the operation, the anaesthetist stayed with her and explained what had happened to her. Therefore, she felt secure.

" The anaesthetist explained to me very clearly the differences between the general anaesthesia and spinal anaesthesia... The anaesthetist throughout the whole process of operation accompanied me. When I was shivering, he held my hand and explained to me that it was the side effect of the drugs. After I know the reason why shivering, I was no more anxious. I felt secure." (Participant 5)

When women were provided with information and explanation about labour

and interventions, they said they felt less anxious and were willing to co-operate with the caregivers.

Childbirth is a special life event for a woman. Women search for information about child-bearing and labour during pregnancy through different channels such as reading books, talking with friends and family members and attending antenatal classes (Porter & Macintyre, 1989). Overall, however, the effect of information from lay sources can develop and reinforce a negative perception of childbirth (McIntosh, 1989). When women were admitted to hospital for delivery, they experienced uncertainty regarding certain aspects including the physiological labour and social, technical and geographical aspects of the hospital. Therefore they sought information of these aspects (Kirkham, 1989). Some women did not attend antenatal classes, they had to depend on midwives teaching them what to do during labour. Even though they had attended antenatal classes, they still needed the midwives to remind and reinforce what they had learnt.

"Even though I had attended the antenatal class about labour process, I forgot all that I had learnt during labour. I highly depended on her [midwife] to teach me what to do." (Participant 14)

Thus information support was important to women no matter they had knowledge about labour or not. Participants felt secure because of receiving

informational support from the caregivers. Information was important at every stage, before, during and even after labour. Many studies confirmed that information support and explanation to the labouring women is strongly related to positive labour experience and elevation of patient satisfaction (Seguin et al, 1989; Field, 1987; Green et al, 1990; Brown & Lumley, 1994). Due to the unpredictable nature of labour and apprehension of labour, information support may offer women a sense of control and understanding of the incidents that can arise during labour.

The findings of this study also demonstrated that good communication during labour between midwives and women particularly in terms of explanation of the reasons for intervention could contribute to women's satisfaction. The relationship of communication or information exchange was the based on mutual understanding, the client understood the situation, and the caregivers gave information and advice in order to gain co-operation but did not "order" them to follow as Participant 5 mentioned.

Participants particularly mentioned information and guidance about bearing down in the interviews. In fact, even thought women had attended antenatal classes about labour, they still found it difficult to perform properly the bearing down action and breathing techniques. Apart from the encouragement and information about progress, women usually needed explicit direction and help with bearing down effects. That included feedback on keeping their perineum relaxed, guiding the force of their bearing down effort towards their perineum and being

assisted to a position where women can achieve effective pushing force for fetal descent (Roberts & Woolley, 1996). According to the findings in this study, some midwives demonstrated effective guidance to women including bearing down force and relaxation exercise. They also used effective communication skill when explaining information throughout the labour process such as performing pushing and breathing exercise with women together. However, the need to "bear-down" or pushing has been questioned. Roberts and Woolley (1994) suggested that facilitating the mother's pushing only when she was an urge to do so has been associated with more effective efforts and less maternal fatigue. The policy of directing women to use early bearing-down efforts may well result in a decrease in the duration of the second of stage, but this does not appear to give any benefit; indeed it is evident that it compromises maternal- fetal gas exchange (Enkin et al, 1995).

Previous studies have suggested that provision of information and clear explanation about the interventions could facilitate women having an active say in decision-making during labour (Seguin et al; Green et al,1990; Brown & Lumley, 1994). However, in this study, there was no evidence showing that participants had a strong will to make decision by their own, or information could facilitate women having informed choice during labour. There were two reasons to explain this phenomenon. Firstly, Levy (1999) found that women might not practise the right of decision-making in an emergency. Women tended to 'Hand over' decision

making to professionals where there was no sufficient time to discuss. Secondly, Levy (2000) stated the importance of trusting relationship between pregnant women and midwives. The degree of trust a woman placed in a midwife was influenced by both of trustworthiness of the information the midwife gave and the personal qualities of the midwife. Participant 14 showed that she *"highly depend on her [midwife] to teach me what to do"*. Besides the perceived quality of information provided, women also took professional and personal attributes of the midwife in account when rating her trustworthiness (Levy, 2000). Therefore, information and guidance support was established on the base of a trusting relationship between the labouring women and caregivers. Bluff and Holloway (1994) also found a similar result about the importance of trust relationship between women and midwives. The study showed that midwives were seen as the experts who 'know best' about the labour. Thus women would like to hand over the authority to professional to make decision about procedures, drugs and type of care during labour. Thus these two points could explain why participants in this study seldom mentioned about the decision-making in the interview. At the same time, Chinese children are taught to obey their parents, teachers and the authorities and Chinese generally tend to be obedient and humble (Bond & Hwang, 1986). Hence, women also tended to follow the instructions from the professionals during labour. It was a difference in the concept and direction of trust between the West and the Chinese. The Chinese in general trusted the professionals. For Western women, the provision of information during labour could help them to actively participate in decision making,

whereas information could provide sense of security to Hong Kong Chinese women. Thus women could be knowledgeable about what was happening to them and they felt secure with peace of mind.

In summary, provision of information and guidance during labour increased the client satisfaction with maternity care. Information and clear explanation helped women to understand what was happening to them. With clear information provided, fear of the unknown and uncertainty could be alleviated. This finding was similar with some studies demonstrated that availability of information during labour is associated with a positive psychological outcome of labour (Green et al; Seguin et al; Brown & Lumley, 1994). However, this study suggests a cultural discrepancy in the underlying reason of satisfaction about information provided between the West and the Chinese. For Western women, the provision of information during labour could expedite them to make the decision and increase the sense of control, whereas the information could provide sense of security to Hong Kong Chinese women. Hong Kong Chinese women have much faith in professionals who make decision to them. They hand over the authority to the professional for making decision. Women only wanted to know what would happen to them during labour and then they would feel secure. Although women feel secure to trust professionals, midwives should empower the client with information to enhance making informed choice by them.

3.Competence & Attitudes of the Caregivers

3.1. Supportive attitude: Encouragement

From the findings, encouragement was regarded as supportive behaviour from midwives during labour and it was frequently revealed by the participants.

" Once I arrived 〔labour room〕, they looked after me very well. As other women had already delivered their babies, I was badly depressed. They talked with me and encouraged me." (Participant 2)

"It was the most effective way to me. They stood around me and cheered loudly, giving encouragement to me. When my baby was coming out, somebody who looked like a pupil midwife, giving encouragement happily. And they [midwives] said, "keep on, the baby's head is coming out" (Participant 14)

"We were very friendly to each other. They [midwives] were like my sisters. They were very keen on helping me. They sometimes told jokes and so did I, They gave me much encouragement. I followed their instruction, for example, how to push, when to push. When I was doing well, they would praise me. Throughout the whole process, I was very happy. I had forgotten my worry. I was very happy especially

when they praised me." (Participant 4)

"The labour was too long and painful so that I was exhausted. I felt relaxed and happy just after delivering the baby. I remembered that the midwives and doctors were quite supportive. Especially when I wanted to give up and not to push... They encouraged me and said that, "You can, you can do it." That made me feel they were very supportive." (Participant 6)

During labour, women have to suffer long hours of uterine contractions facing intense physical and emotional stresses. Pain, fatigue, fear and anxiety, they experienced all of them (Lindsjö & Petra 2000; Hallorsdottir & Karlsdottir, 1996). Therefore, encouragement was an important emotional support to strengthen them facing the stressful situation during labour.

Participants expressed satisfaction with caregivers' encouragement during labour. Midwives utilized good communication skill to give encouragement to the women, for example, "they praised me", " were friendly", "telling jokes", " cheer loudly" as well as "giving encouragement happily". Encouragement could reinforce women's strength to cope with stress during the second stage of labour. Similar findings were covered in a longitudinal qualitative study in England (Fraser, 1999). The study regarded this kind of midwifery care as being a professional or

friend to childbearing women.

Encouragement also consisted of the element 'praise me'. A study (Holroyd et al, 1996) found that the term 'praise me' was rated by Hong Kong Chinese women as the most important supportive behaviours given by the midwives. Holroyd et al interpreted this phenomenon as relating to Chinese belief of 'face'. In Chinese 'having face' literally means being respected in social interaction. Praising or preventing shame was a kind of cultural behaviour among Chinese to save anothers' face (Leininger, 1995). On the other hand, when Chinese people are in a situation of embarrassment, shame, anxiety and self-blame, they will take compensatory action in order to save face. Thus one will work hard to restore or maintain others' face (Bond & Hwang, 1986). In order to prevent 'losing face', women reacted by doing their best to maintain their dignity during labour.

"During labour, I told myself that I had to control myself and not be so crazy in front of my husband and the midwives... With the support and encouragement [from her husband], I told myself ' Don't lose face'." (Participant 10)

In summary, this "praise me" can provide support to the women, giving and helping maintain 'face'. Encouragement can act as an activator to reinforce the inner strength of the women, protecting and restoring their dignity and face. Therefore providing 'encouragement' and 'praise' are a culturally congruent with

care to Chinese women. They were 'given face' and that could prevent them going into the situation of 'losing face'.

3.2. Competence of the Caregivers

Being as the health care professionals, clinical competence is not only a crucial, but also fundamental element. The competence of staff may affect the quality of care providing to the clients.

A woman described a incident about an incompetent staff in which she encountered during labour:-

" Mainly [dissatisfaction] about the incident of blood taking. You know. Blood had to taken from me every 2 hours so as to check my blood sugar level. Honestly, some doctors were very nice. However, some doctors were not concern about the patient's feeling during blood taking. For example, I had a glucose drip on my hand. But he [doctor] collected blood from the same hand where the drip was set. Afterward, he discovered that the blood glucose level was extremely high. Then he collected a blood specimen once again . . . . Because of his fault, I had to repeat blood taking again. Although blood could be generated again, blood taking was very painful. He was not acting responsibly. He should think about it before collecting blood. That incident made me feel unhappy." (Participant 5)

Throughout the labour journey, competent and experienced midwives could provide high quality of care to women. Thus women appreciated midwives' professional skill and knowledge which make the labour became smooth running.

"They observed my condition. They taught me when to push, how to push and how to breathe. That meant they taught me many things. I appreciated that they could handle the situation calmly." (Participant 4)

" She investigated the reason why there were good contractions but with slow progress of labour. She asked me whether I had an urge to pass urine or not. Oh! I was so concentrated in my pain, I forgot to go to toilet. After I passed urine, labour progress went fast. She was great [an experienced midwife]." (Participant 14)

Midwives were "knowledgeable" to provide sufficient information. They were "experienced" to handle problems. They could do their job calmly. These were regarded as the attributes of competent caregivers.

"They were caring. They had informed me before they performed every procedure to me. When I was confused, they [midwives] were working together co-operatively in order to help me." (Participant 12)

Competence implies ability to perform the task appropriately (Fitzpatrick, 1997). Health caregivers need to handle human related task that may greatly affect people's life. Competence is a fundamental element of health care professionalism. Competent staff can provide a sense of security to the patient (Field, 1987). Fitzpatrick (1997) stated that patients might be able to judge the interpersonal skills of health professionals but not the aspects of technical competence. To some extent, this must be the case by no way could a patient understand sophisticated medical technology used in clinical practice. From the findings of the study, however, participants did judge the competence of staff when medical technology used was simple. They judged who was competent or not simply by the quality of care they received. Women did observe carefully what the staff had done to them. Meanwhile, the participants revealed some words or phrases about midwives' ability including "knowledgeable", "experienced", "managed the situation calmly" and "co-operative among staff". The participants regarded those attributes of staff as competent.

Participant 5 observed the doctor did his task wrongly during blood taking. She reacted as follows:-

" But I had no power to fight back. I did not dare to speak out. I even dared not to say he was wrong. I had no choice. I kept silent because he was a doctor. I was very unhappy about that." (Participant 5)

She dared not voice out her dissatisfaction because she thought she had "no power to fight back". Therefore, she was discontented but she still kept silent because "he was a doctor". This illustrated another issue about imbalance of power between women and the professionals especially the doctors. Participant 5 had a typical personality of Chinese people, being submissive, obedient and patient to the authority (Yang, 1986). She dared not criticize the staff during hospitalization. In fact, she did not accept this kind of inappropriate care. It may reflect an emerging issue in Hong Kong Chinese about power and empowerment. Further investigation of these issues should be conducted. Clients' inquiry may act as an external force to motivate the professionals improving the quality of care and accountability is warranted in a Hong Kong Chinese setting (Krowinskin & Steiber, 1996).

3.3 Caring Attitude of Caregivers

The attitude of caregivers is an important factor influencing the clients' perception towards the service provided. There were some incidents about the attitude of staff including both positive and negative attitude.

" *The doctor seemed to do the routine only such as asking history, abdominal*

examination. But the midwives were different. The midwives asked questions in detail delicately and friendly. They were caring. They would inform me before doing anything to me." (Participant 12)

" When he [doctor] arrived, he immediately started suturing without telling me what he was going to do. I said, "NO! It was very painful." I asked for analgesia. Then he gave me two injections." (Participant 11)

" Some midwives could show their concern and consideration from the clients perspectives. I meant they knew how to make me feel comfortable and reassured me. That part of service was the best one." (Participant 14)

" I meant there were many midwives including Ward Sister. I was not sure which one was Sister or midwives. But I felt it was so impressive that those experienced midwives took care of me in a good attitude such as they knew how to reassure me or telling me something to help me. However, those younger midwives, obviously, their attitude or manner was rude. Obviously, I could differentiate them in that way. I meant... not so bad actually, comparatively, they were not so good as those older ones. The latter one knew how to use some words to reassure me. They knew what to do in order to make me feel secure and comfortable throughout the whole process. However, those younger midwives, they answered my questions in very short sentence and that's all." (Participant 7)

Interaction between caregivers and labouring women occurs by the verbal and non-verbal communication. Aspects of verbal communication, such as informational support have been discussed in the previous section. On the other side, the non-verbal part of communication, for instances, tone of voice and attitude can influence the relationship between women and the caregivers. Communication is an important component of effective midwifery care (Hunt & Symonds, 1995). Difference in attitude, manner and tone of voice result in various communication consequences. Kirkham (1993) stated that "Communication is the vehicle by which all else is learnt and relationships are built. Communication cannot be separated from other areas of care because care is built on and of communication." (p.2). Kirkham (1989) referred to "verbal asepsis" in her study about information giving during labour, when midwives tried to block the conversation or turned the conversation away from the topic on which the women wanted to seek information. Midwives implemented a "linguistic non-touch technique" in order to sterilize the conversation and did not allow midwives themselves to contact with the woman's worries or concern. In this study, Participant 7 had a similar experience as Kirkham described. Participant 7 reported that those younger midwives only answered her questions in very short sentences and then ended the conversation quickly. They did give information to Participant 7, but it was not a high priority, and the woman perceived that they tended to block the conversation as soon as possible. In that situation, it might reflect that those younger or junior midwives might perform "verbal asepsis" to the woman or they

might have not enough confidence and related knowledge to face the questions of the participant (Kirkham, 1989). Conversations between women and some midwives were found to be short in duration and superficial. A study (Yam and Rossiter, 2000) explored Hong Kong Chinese nurses' perceptions towards caring attitude. Those nurses acknowledged that they could not spend much time to talk with the clients because of some constraints in the clinical setting in Hong Kong such as shortage of staff, convention task-oriented working attitude and insufficient training in communication skills. Therefore, midwives should make some efforts to overcome the constraints in clinical setting in order to improve the communication to the clients. Fraser (1999) found that good communication was given a high priority. Unless women had a relaxed and trusting relationship with the caregivers, they tended to hold back, did not hear what was said or felt in some way dissatisfied with their care.

Technical competence is a basic requirement for the health care service. If "competence" did not come together with "caring attitude", women perceived that a health care worker completed a task only, when "competency" worked hand-in-hand with "good attitude", they would be regarded as caring midwives or caring staff. As an example, Participant 7 described the Ward Sister, as knowledgeable with good attitude. Studies indicates that women in labour greatly appreciated, not only the technical skills of midwives, but also the emotional support from the health care professionals (Hillan, 1992; McNiver, Hodnett & O'Brien-Pillas, 1993). Therefore, Participant 7 perceived "make other feel secure and comfortable throughout the

whole process." And Participant 14 also mentioned that some midwives with attribute of caring attitude were regarded as the most precious part of maternity care. Thus the impression about the care provided could be greatly influenced by caring attitude of the caregivers.

In conclusion, there is a close relationship between technical competence and attitudes of caregivers. Leininger (1988) stated that " caring is an extremely important and generic construct in human services. It appears to be the heart of all health care services." (p.4). Caring is an essential component of our daily midwifery practice. Caring also includes different ideas, for example, tenderness, compassion, empathy and mutual trust relationship (Leininger, 1988). A competent health caregiver should possess not only updated knowledge and skills but also caring attitude.

4. Physical Comfort

During labour, women said they suffered from contractions pain, thirsty and tiredness. Provision of physical comfort contributed to the women's satisfaction. According to the findings of the study, two special areas concerning physical comfort mentioned frequently by participants were providing warmth and perineal wound care in order to eliminate their worry about 'cold' and wound infection. Therefore, they felt secure. Furthermore, pain relief was also a crucial

element to provide physical comfort to women.

4.1. Providing warmth, avoid 'cold'

"Felt cold" seemed to be common after physical effort of labour in this study.

"*Immediately after delivery, I was very tired and felt cold. The midwives were very kind. They treated me very well, for example, offering warm water and blankets to me.*" *(Participant 3)*

" *I felt cold, they gave me blankets. Sometime, they did better than my husband in taking care of me. They helped me put on the blanket to avoid 'cold'. They also took care of my husband.*" *(Participant 5)*

" *The midwives in labour room were very helpful. Maybe related to my career. I was a nurse too. I could feel that they were caring. They even took care of me in a minute way. For example, they asked if I felt cold or not, thirsty and so on.*" *(Participant 10)*

"The thing I disliked most was - coldness in the labour room." (Participant 7)

All in all, the women expressed that they were satisfied with the physical care they received. They put much value on this kind of physical nursing care "Providing warmth, avoid cold". In fact, women regarded this as care and concern, it was more than physical. It represented a caring behaviour of midwives.

The phrase "Providing warmth, avoid cold" was mentioned by the several participants in the interview. This is especially significant in the Chinese culture related to the theory of hot and cold. Chinese believes that the interplay of 'hotness' and 'coldness' (Yin-yang theory) helps maintaining equilibrium of inner bodies. Chinese women believe that childbirth and the first month after parturition is the time that the body is vulnerable and easily gets 'wind' and 'coldness' (Chang, 1995). Exposure to 'winds' or 'coldness' may result in physical problems such as coughing, headache and muscle pain and their manifestations may even occur years later when they get old (Leininger, 1995). Hence, many postpartum women have this worry about getting cold (Chang, 1995). In addition to the meaning of exposure of bodies to cold environment, 'coldness' in Chinese health belief means ingestion of food that is "cold". Food is categorized in to "hot" and "cold" in Chinese in a way that it hard to understand particularly for foreigners. For example, red-bean soup and ginger soup are regarded as "hot" in nature no matter it is in high or low temperature. Fruit is regarded as "cold" in nature. Water is neutral in

nature. However, in general water that has a high temperature are regarded as "hot". On the other hand, drinks that have a low temperature are regarded as "cold". Given the above-mentioned health theories of "hotness" and "coldness", it is not surprising that women in the interview appreciated the midwives very much for the provision of blankets and warm water.

The finding of this study are consistent with another local study (Holroyd et al, 1996) about midwife support during labour in which a Chinese woman commented "keeping the environment warm, providing extra blankets avoid exposure to cold" as an extra dimension of midwife support apart from the fixed items provided by the Bryanton Adaptation of Nursing Support in Labour Questionnaire used by Holyrod et al. Not only was this the case in this study in Hong Kong but also in the North of England, where group of Chinese women that expressed concern about 'hot' and 'cold' during pregnancy and childbirth (Neile, 2000).

Besides being a Chinese health belief, keeping warm is also one of the components of the lowest level of human needs in Maslow's hierarchy. The second level in Maslow's hierarchy includes safety and security (Kau, 1995). Hence, satisfy the need of warmth of the women, they could have a sense of security. It has been said that it is a duty of midwives to maintain comfortable environment for delivery including suitable temperature and humidity (Robertson, 1997). After all, warmth is just a basic human need and contribution to a feeling of security and

comfort.

4.2 Perineal Wound Care

The perineal wound care seemed to be particularly important to those women who were vaginal delivery with an episiotomy wound.

" Cleanliness. That was quite good. When I had delivered my baby, they helped me clean up my bottom and [perineal] wound. Actually, the midwives were quite nice." (Participant 11)

"After parturition, it would be better if the wound 〔episiotomy〕could be cleaned by the midwives several times. They just did it once and never did it again. I expected that they could clean my wound each day. I had to do it myself. How could I do that? I really could not make it. They could do much better with swabs and make it really clean... It would be cleaner if they helped me. Besides, the doctor did not check the wound daily. I remember in the occasion of delivery of my first baby, the doctors examined the wound daily. In that case, the progress of healing was known. I was very worried if the wound could burst open. Coughing or sitting on the wound might make the wound gape" (Participant 9)

In Hong Kong midwifery practice, vulval swabbing and situ bathing are recommended as prophylactic measures in reducing the risk the perineal infection and relieving perineal discomfort. Vulval swabbing is performed after women are just having an episiotomy suturing or delivery. When post-natal women are ambulatory, they are advised to performed swabbing or situ bathing by themselves. Chinese women usually do not take a bath for several days after delivery in order to avoid getting 'cold'. Women acknowledged that cleanliness and vulval swabbing was important to them to maintain perineal wound cleanliness. They worried about wound problems such as unhealed wound and wound infection. One woman felt that it was unsafe that no health care professionals took care of her wound after delivery. Although an episiotomy wound is a simple sutured wound, some women might find it difficult to manage it properly. The woman expected the perineal wound was taken care by the caregivers, in fact, she had to take care the wound by herself. Women said that they needed professional support for the perineal care. Then there was a discrepancy between her expectation and the fact.

In summary, concerning women's physical needs such as providing warmth and wound care was regarded as caring behaviours of the caregiver from women's perspective. With provision of warmth and wound care, they felt secure and need not worry about "cold" and wound infection.

4.3. Pain Management

Pain in labour is unique. Pain in labour usually is regarded as "natural", normal and not the result of some pathological conditions (Moore, 1997). However, fear of pain was not uncommon among the pregnant women (Lindsjö and Petra ,2000; Kitzinger, 1978). Chapman (1977) defined the concept of pain as a product of the individual's response to noxious sensory input that was affected by the interactive influences of social and cultural, conceptual and judgmental, and emotional factors.

In Hong Kong, epidural anaglesia and Entonox are the most common pharmcological methods of pain relief during labour. Eight of the participants in the study chose or were offered epidural analgesia during labour.

As a woman who chose epidural analgesia during labour stated about her perception towards pain management during labour:

"I mean... a long time ago, Chinese women could give birth naturally. However, being as a modern woman, there are many devices and methods to alleviate pain during labour. It is unnecessary for us to suffer from pain. Why not try it [epidural analgesia] ?" (Participant 10)

To certain extent, this may reflected that there was a desire of "painless" labour among the Hong Kong Chinese women.

Some participants chose epidural analgesia, they had some positive comments towards this kind of pain relief:

" I had heard that some mothers were interviewed for this opinion about epidural analgesia in the post-natal ward. Those women said that it was not good enough. I thought why the staff did not ask my opinion. For me, it was a very good service. Those women commented that it caused back pain. Conversely, I felt it was so good to me and I felt no pain at all." (Participant 8)

"In this delivery, I tried epidural anaglesia during labour. No pain at all. After delivery, I still felt pain free. In delivery last time, I had taken a lot of analgesia. At this time of delivery, it was painless. Although the anaesthetist reminded me that epidural analgesia might not be so helpful for me, it was quite helpful for me during late stage of labour. At least, I was free from pain for several hours after delivery." (Participant 4)

" Without epidural analgesia during labour, I guess I would suffer from pain very much. . . It is a good thing if we can use it properly. Because of advancement of medical technology, it is unnecessary for us to suffer from labour pain." (Participant 10)

There was a complaint from a woman about pain relief during labour.

" I was dissatisfied with the fact that they did not tell me anything about epidural analgesia." (Participant 14)

The woman was dissatisfied with not being acknowledged about she had a right to request epidural analgesia during labour.

Women approach the relief pain with a diversity of views. Some of them want complete abolition of pain but others want the satisfaction of labouring without any kind pharmacological aid (Bevis, 1997). Sense of control is well known as an important factor in a satisfying experience of childbirth (Green et al, 1990; Murray et al, 1996). From the findings of the study, many participants who had chosen epidural anaglesia were satisfied with it. Epidural analgesia provided a "pain-free" labour to women. These women were free from pain during labour and it may be another kind of sense of control over the labour pain.

Apart from the pharmacological approach to labour pain, psychological support also appeared an effective method to alleviate pain during labour.

Some participants recalled their memories about midwives how to alleviate their pain as follows:-

"I was very impressed by the kindness of the midwives in labour room. I was very satisfied with the care provided by staff of labour room. They talked with me to distract my painful feeling, for example, they chatted with me where and when I had delivered last time." (Participant 1)

"I meant they gave me confidence. They reassured me ' Don't be afraid.' They kept talking about something with me. That made me less anxious and panicky. They distracted my concentration from pain." (Participant 9)

"Chatting" or "talking" was a method to distract painful feeling and reassurance was frequently used to alleviate pain by the midwives. In fact, keeping talking with the women could reduce women's anxiety level, thus they felt less nervous and painful (Moore, 1997). And emotional support such as being there and encouragement could contribute to help women keep calm and have confidence

to cope with pain.

On the other hand, a participant voiced out her labour pain to the staff after having epidural analgesia. However, the midwives did not believe her to be in great pain because she was only in the stage of 2 centimeters dilatation of cervical os. They ignored her call for help. The woman felt discontented.

"*The most disliked matter was about the anaesthetist. He [the anaesthetist] gave me an injection [epidural injection] to me, then he ignored me... I felt pain when the opening [cervical os dilatation] was 2cm. The gas [Entonox] was not useful to me. Therefore, I was offered epidural analgesia. But I felt unhappy that midwives in the antenatal ward ignored my complaint of pain. I was in great pain but they {midwives] did not believe me . . . good [midwives] means showing concern to my pain, asking my feeling. Some [midwives] neglected my pain even when I pressed the call bell. They did not respond to my call immediately and just said OK and OK. And did nothing to me... Good [midwives] meant responding to my call immediately, reassuring me and taking action at once to find what was wrong with me." (Participant 1)*

In this incident, problems related to pain management appeared. Although pain in labour is regarded as natural, normal and not related to the result of any pathological condition, the woman wanted midwives to acknowledge, respond

to her pain. Without response to the call immediately, the woman felt being neglected. On top of pharmacological and psychological measures that have been mentioned beforehand, good communication as well as a trusting relationship between the staff and labouring women appeared as a significant factor to influence the pain management and satisfaction. Participant 1 mentioned that "they did not believe me". The staff did not trust the subjective feeling of pain and did not respond to her call immediately. The distrust relationship influenced judgement of staff to manage pain and also blocked the communication with the client.

Trust was also crucial to the relationship, as Lundgren and Dahlerg (1998) found in a study of women's experiences of pain in labour. Women described they coped with pain during labour by having trust in the people around them, their husbands and the midwives.

In conclusion, labour pain is probably the most painful event in the lives of many women (Melzack, 1984). Consequently the majority of participants required and used some forms of analgesia during labour. Morgan, Bulpitt, Clifton & Lewis (1982) found that low pain scores did not relate to high levels of satisfaction, the implications being that satisfaction may be concerned with how well they have coped with labour pain rather than effectiveness of pain relief. However, in this study effective pain management including pharmacological especially epidural analgesia or psychological methods did make women felt satisfied with care during

labour. Furthermore, the mutual trust relationship between woman and midwife was a central element of effective pain management during labour.

5. Outcome of Labour

Women view labour as both a vital and stressful life event, expecting a safe childbirth associated with an experience which is positive and satisfy (Mackey & Stephans, 1993). For mother, the labour process itself affects the mothers' outcome of labour, for instance, mode of delivery. Healthy babies are an expected outcome for women and their families.

5.1.Seeing a Healthy Baby

" I was very happy that I could see my baby just after delivery." (Participant 1)

" In private hospital, I only saw my baby three days after delivery through the window. Therefore, I felt totally different in there. I could see and hold my baby just after delivery. The feeling was so concrete and nice. It was totally different feeling." (Participant 4)

" My first impression was that I no longer had to push. And then I felt happy.

I could see my baby's head and then the body was coming out. I needed not to push, I felt so relaxed. A midwife let me see my baby. I felt so relaxed." (Participant 8)

" The feeling... feeling so relaxed... um... just like unloading a heavy burden. I delivered the baby uneventfully. I delivered a normal baby. They let me have a look at my baby. Thus, I felt so relaxed. . . It was nice, such as touching my baby. The baby was so warm. Then I could feel that it was a reality. I really gave birth to a healthy baby." (Participant 14)

Giving birth to a healthy baby has a special meaning to the mothers. First of all, the unknown and uncertainty during pregnancy had gone when the child was born. Lovely babies were put in front of the mothers. Looking at the newborn babies, women had a sense of security as they had been assured of health of the babies and it was their expectations. Worries had gone when the mothers could see their babies. Secondly, the mothers considered that it was worth to endure the labour pain and exhaustion when the babies were normal and healthy. Healthy babies were big reward for the mothers who had just gone through delivery.

A woman complained that she was neglected by the caregivers during the early stage of labour. She claimed that she had a lot of bloody discharge during onset of labour. Both doctors and midwives explained that it was "show" and it was normal blood stained discharge from the cervical os. However, the woman

said that those caregivers gave the explanation about the bloody discharge without inspecting her soiled sanitary pads. Therefore, she insisted of claiming that it may be antepartum haemorrhage and required further actions to encounter this condition. However, the caregivers did not do anything more to her except reassuring. So she discontented with their management. Finally, she gave birth to a healthy baby.

" For the labour care, it was not so good. Because "touch wood", I was very lucky. I delivered a healthy baby. If my baby had any problem, I would like to think what had happened during labour causing the fault. Maybe negligence of care occurred during labour, so that unhappy thing happened. For example, they did not concern the matter of vaginal bleeding that I had mentioned during admission. Maybe it was a sign of antepartum haemorrhage." (Participant 10)

Participant 10 commented that there was nothing more important than her baby being normal and healthy. She would no longer be concerned with something going wrong during the labour process. She was satisfied because she had a good birth outcome. As Participant 10 said, she would like to criticize the care provided and find out any fault occurred during labour. Women might be prone to be dissatisfied to the service provided.

Furthermore, women perceived that giving birth to healthy babies was very important in the labour process in this study. Procter (1998) reported the

experience of positive birth outcome seemed to give many women confidence to criticize the service provided. A study (Driedger, 1991) reported that even all participants in the study had positive birth outcomes, healthy babies, they still were dissatisfied with care. On the contrary, this study found that the positive birth outcome, a healthy baby, might act as a buffer to soothing the dissatisfaction with service provided or the dissatisfaction may not so severe enough for provoke them to make a formal complaint. Due to the submissive personality of Chinese people, the mothers usually tend to avoid making trouble or complaint to the service if their baby is healthy (Yang, 1987).

5.2. The Labour Process

The medical model of obstetric practice in Hong Kong, many interventions may be performed to women to achieve an active management of labour as well as safe childbirth such as vacuum extraction delivery, augmentation of labour and caesarean section.

The woman (Participant 2) delivered her baby by means of caesarean section because of failure of induction. She felt "regret" because of choosing

epidural analgesia during labour. She believed that epidural analgesia was the main cause of no progress of labour.

" I regretted. Maybe I was afraid of pain. My colleagues told me that after giving epidural analgesia, the contraction pain would be decreased... But it was different in the real situation... When I felt contraction, I pushed hard. But it did not work. If I did not choose epidural analgesia, it might be open faster. I could feel pain by myself, it might open faster (cervical os). So, I regretted." (Participant 2)

Another woman also experienced no progress during labour. Although she did not feel "regret", she felt "disappointed" because she could not give birth naturally.

" A woman next to me had delivered a baby. When she was laboring, midwives taught her what to do. I listened what they said to the woman. I thought I would be the same when it was my turn. However, I was badly disappointed. I had prepared myself to give birth to my baby, for example reading books, attending classes. I found that those things meaningless to me. It was because I gave birth to my baby by means of Caesarean section." (Participant 13)

Another woman showed her dissatisfaction with the service provided. She suffered from a severe tear of her perineum during labour. She was

discontented the hospital policy that an episiotomy was not performed because it was her third time delivery.

" 90 marks for the overall care provided. 10 mark is off because of the perineal wound and suturing. The midwife should assess my condition such as the size of my baby. As my baby was so big, they should make a cut on my perineum. My perineum might not tear. They should not only follow the routine: no episiotomy to woman who has the third time delivery. I had different experience about that. Last time of delivery, I had a cut [on perineum]. A doctor repaired the wound within a short period of time. The wound healed very soon. This time of delivery, my wound did not heal very well . . . I asked the midwife who repaired my wound about how many stitches were made. She did not reply . . . I also asked her why they did not cut a wound [episiotomy]. She also explained that episiotomy was a thicker wound. She said that the torn wound was thinner than the episiotomy. However, she repaired the wound for a long time. Thus I asked her why they did not make a cut? The wound could not heal so well. I still feel pain. Before that, I guess it would be better if no perineal wound was made during labour. However, the pain [of the torn wound] is just the same as that of episiotomy. I prefer making a cut." (Participant 12)

On top of giving birth of healthy baby, the labour process itself is also important factor to influence the impression of the women's birth experience and satisfaction towards labour.

Participant 2 and 13 also experienced the similar situation of unplanned emergency caesarean birth in the labour process. They expressed their feelings by using negative emotion wordings such as " regret" and "disappointed". They had a definite onset of labour, they experienced the contraction pain. They also were looking forward to giving birth very soon. However, there were some unpredictable problems, no progress of labour and prolonged labour. With medicalization and active management of maternity care in Hong Kong, they had to face the unexpected situation, the caesarean section. Although both of them had a healthy baby, they still responded negatively to the labour. The phenomena seemed to contradict the previous discussion of "seeing a newborn baby". "Seeing a newborn baby" or "having a healthy baby" and positive labour experience are two different perspective of a labour. It did reflect that the complex nature of labour satisfaction. Driedger (1991), in her study about labour satisfaction, found that even though all participants had a good outcome (a healthy baby) in her study, some of the participants still felt dissatisfied with the care provided. Thus Driedger explained that it was not a simple relation between the patient satisfaction and the outcome. A good outcome (baby) did not equate to higher level of client satisfaction. Women are expected to be happy after a caesarean section because their babies are safe (Hammett, 1997; Proctor, 1998). Nevertheless, Brown & Lumley (1994) found that the more interventions given during labour, for instance, instrumental delivery and caesarean birth, the more dissatisfaction with care arose. The feelings of disappointment, failure and anger of the women were ignored by the

healthcare professionals (Hammett, 1997).

Green, Coupland and Kitzinger (1998) commented that women were much likely to welcome those major interventions such as caesarean section when they knew that the intervention saved their baby from danger. Therefore, Hammett (1997) advocated that one-to-one labour debriefing should be provided for all women after delivery especially for those who had traumatic delivery. The labour debriefing could be defined as a process of recalling events and clarify the details of trauma and painful experiences of labour by post-natal women. During the process of debriefing, a tendency to suppress unpleasant event would be counteracted. The labour debriefing usually involved active listening to the women, sometimes also husbands as well, who expressed their feelings of their experience. Midwives must posses sufficient knowledge and communication skills to handle the situation. It was also regarded as cues to form one of the diagnostic criteria for post-traumatic stress disorder (Hammett, 1997; Alexander, 1998). Through the process of labour debriefing, both midwives and post-natal mothers can benefit. Mothers can have an opportunity to debrief their labour experience, whereas, the "missing pieces" of the labour and misunderstanding to the interventions can be clarified by the health caregivers. Thus they could felt that " the right thing was done to me". For example, if Participant 2 could have had labour debriefing during the postnatal period, she may have reduced the sense of guilt or "regret" to chose epidural analgesia in her view causing caesarean birth. Indeed, there was no evident support

that epidural analgesia could lead to delay the progress of labour (Bevis, 1997). Under the policy of active management of labour in Hong Kong, caesarean section usually will be performed for those who cannot give birth twelve hours after the onset of labour. In this aspect, labour debriefing can help the women to increase confidence in their ability to motherhood and her self-esteem in order to facilitate psychological adjustment to motherhood.

On the other hand midwives can gain the feedback from women through the labour debriefing. Thus midwives could improve their communication skill, self-awareness and midwifery practice (Hammett, 1997). In the case of Participant 12, midwives could gain an understanding about women's perception of episiotomy, so as to increase awareness about the practice of episiotomy. The routine use of the episiotomy in the obstetrical practice is controversial (Enkin et al, 1995). In recent decades, there has been a movement towards natural of childbirth in the Western countries especially in the United Kingdom. Both the layman and healthcare professionals began to question the scientific evidence of routine episiotomy. Hence, there is a significant drop of performing routine episiotomy in the practice (Graham, 1997). On the contrary, women in the study seemed to be adapted to the routinization of episiotomy during childbirth. Participant 9 also questioned why the midwife did not perform episiotomy for her. Another woman, Participant 7, a multipara stated that:

"They [midwives] said that episiotomy might not be performed but I requested to have episiotomy. It was because tearing of perineum would be healed less better than the episiotomy."

Both participant 9 & 7 were not against the episiotomy and showed their preference for it. They also accepted that it was the norm to have episiotomy during labour. There was a difference in perception towards episiotomy between the Hong Kong Chinese women and Western women. It may be the result of liberal use of episiotomy to all women who are first and second delivery in Hong Kong.

In summary, having a healthy baby provided a sense of security to the women and they felt that it made suffering worthwhile. However, "a healthy baby" is not the only factor to influence women's satisfaction towards labour. Even though women had healthy babies after delivery, some of them still showed dissatisfaction with care provided. The healthcare professionals sometimes cannot control the outcome of labour, the baby and delivery process itself. Those women who had traumatic delivery should be provided with something like labour debriefing to voice out their negative feeling towards labour afterward. Through the process of labour debriefing, both health caregivers and postnatal women will increase their understanding of each other. However, there has been no systemic evaluation of the effectiveness of labour debriefing in the clinical setting. There is

a need to further research to support its effectiveness to women satisfaction towards maternity care (Alexander, 1998).

6. Environment and Facilities

In this study, environment and facilities did not appear to positively contribute to the sense of security during labour. On the contrary, environment and facilities especially the birthing bed did contribute to the sense of insecurity and unsafe to women.

" The bed was narrow. And I was put aside [at the corner of the room]. Not comfortable. I meant I was anxious and was put aside. They did not neglect me. But I felt uneasy with the environment where was not suitable for giving birth to my baby." (Participant 2)

" I thought my legs should not been hung so high. The position of my legs was too high for me to bear down easily. The midwives should ask the women whether the legs were in a comfortable position or not. It would be better... A good positioning of the legs could facilitate pushing during my last time delivery in a private hospital. Because of my legs were too high, I could not push easily. I meant that my legs was put in a natural way during my first time delivery. Just like that... [the

participant demonstrated the positioning of her legs]... just like that... seemed to be separated into two pieces. The position did not facilitate me to bear down. My legs shivered and I was in fear. I did not know what to do at the moment." (Participant 9)

"The bed. The birthing bed was quite out-dated. Birthing bed is very comfortable in X Hospital [private hospital]. A birthing bed can help the women pushing. The bed made me feel uncomfortable. The position of hanging my legs was too backward. After delivery, my legs became numb. Therefore, I requested to be released from the stirrups for a while. Handles of the birthing bed were loosening. Great force was needed in labour. So it was very dangerous. After delivery, both my legs and hands became numb. I discovered that the main problem was the bed." (Participant 4)

"The birthing bed was so narrow . . . I was nearly falling down from the bed. . .The E hospital [another public hospital] had new model of birthing bed which was more comfortable." (Participant 7)

" The toilet was very dirty." (Participant 8)

" The thing I disliked most was- coldness in the labour room." (Participant 7)

Four participants pointed out the same problem of design of the birthing bed in the labour room. Participant 2 was a primiparous. Therefore, she only emphasized that the bed was so narrow. Participant 4, 7 and 9 were not the first time mothers. They had the experience of giving birth to babies. By comparing with the previous labour experience, they could describe the problems of the birthing bed in detail. They commented that the design of the birthing bed was not so good to facilitate their pushing effort during the second stage of labour. And the handles of the birthing bed were loosened. Therefore, the birthing bed of that hospital seemed to be unsafe, as the women perceived. Therefore, they felt unsafe and insecure with this kind of facility.

Furthermore, the maternal position for birth can affect the maternal effort for bearing down and fetal head descent. There is a consensus that the supine lithotomy position should be avoided. Roberts & Woolley (1996) stated that the supine lithotomy position produces decreasing blood supply to the fetus and it also associated with maternal pain and makes the woman's bearing down more difficult. They suggested that a variety of upright and recumbent positions could be used during second stage of labour and for birth. However, it is a usual practice in Hong Kong to arrange labouring women in lithotomy position for delivery. This practice is questionable.

Furthermore, the physical environment of the hospital such as cleanliness and temperature of the ward could contribute to the women's satisfaction with care during labour.

The Midwife-client Relationship: A Trusting Relationship

A trusting relationship has been described as an essential element of building up a therapeutic caregivers-clients relationship in the health care service (Bradley & Edinber, 1986; Sundeen, Stuart, Rankin & Cohen, 1989).

A woman stated that she trusted the staff of the antenatal clinic. Therefore, she hoped that this group of antenatal clinic staff could take care of her during labour. Continuity of carer facilitated in building up a trusting relationship between women and caregivers.

" I think it would better if clinic midwives could take care of me during labour. If they could take care of me during labour, I would feel more secure . . . During the antenatal period, I visited the clinic quite frequently, for example, monthly and even weekly. With more interactions with staff, a sense of trust, warmth and security had been built up. They were doing well in the antenatal clinic. Therefore, I trusted them. Maybe I preferred being taken care by those midwives I knew & trusted. Maybe I

would feel less anxious and was panic when I could see familiar faces" (Participant 9)

Another woman said that she felt easy when she saw some health caregivers known to her before.

"The doctors recognized me. I had been admitted to hospital because of a low blood sugar level. In the ward, many doctors recognized me. They also chatted with me . . . All doctors I had seen before. I knew midwives in the antenatal ward very well. Therefore, I felt easy." (Participant 8)

Another woman also stated that she felt confidence in this hospital because of a harmonious interpersonal relationship established with the staff.

"During pregnancy, I had heard somebody said that it was no good to confine in that hospital. For example, they told me a story about one of twin babies who was dead. It made me feel anxious. However, the more antenatal visits I had attended, the more confidence were built up. The midwives were friendly. Those horrible stories about this hospital did not reflect the truth . . . I had confidence to confine in that hospital." (Participant 4)

Those three participants (4,8 & 9) stated that their trusting relationship with caregivers had been established since the antenatal period. Client satisfaction

during labour was not solely related to the staff of labour room, but also the total impression about the whole maternity unit. The trusting relationship was cultivated when the women attended the antenatal visits.

Participant 9 showed her preference that she wanted to be taken care of by the same group of clinic midwives during labour. She perceived that those clinic midwives were competent. A complex issue of continuity of caregivers is raised. Participant emphasized the importance of meeting the midwife caring for them before the event. But they did not mention about the continuity of care during labour. Their vulnerability and anxiety perhaps would be reduced by care provided by a known midwife than "strangers". The importance of continuity of caregiver can be conflicting in the literature (Lee, 1997). Lee stated that continuity of care did not only mean to provide care by the same health caregiver and continuity of carer was only a part of the concept of continuity of care in the United Kingdom. Lee also suggested that there were several problems if the system was changed for serving the purpose of providing continuity of carer during labour. For instance, there was a practical limitation to arrange midwives for 24-hour on-call facilities for provision of care to their own group of clients. Meanwhile, Levy (2000) asserted that trusting relationship could be established, even if the women were not taken care by the same midwife during labour, feelings of trust in individual staff can lead to confidence in the whole maternity unit.

Furthermore, Lee (1997) argued that women did not know how to express their need for good quality of care and stated, "many women's desire for continuity of carer stems at least in part from a desire to be able to predict her future (good) care by a (known) midwife, because she is unlikely to be able to control her care in any other way."(p.19). In fact, women desired to receive good care regardless of knowing the carer.

Hence, quality antenatal care and continuity of carer became gatekeepers to provide excellent care to the clients and their families and it can facilitate trust relationship establishment and elevation of client satisfaction. Midwife-led clinics for normal pregnancy can facilitate the rapport establishment between the midwives and clients during antenatal period (Hundley et al, 1997).

In previous section of this chapter, a trusting relationship had been mentioned that it could affect the pain management during labour, how much women believe midwives to help them alleviate pain, and how much the midwives believe pain intensity of women. Trusting relationship is a fundamental element for building up women's satisfaction information and guidance support as well as competence and attitudes of the caregivers that had been discussion in previous sections (Refer to Figure 3).

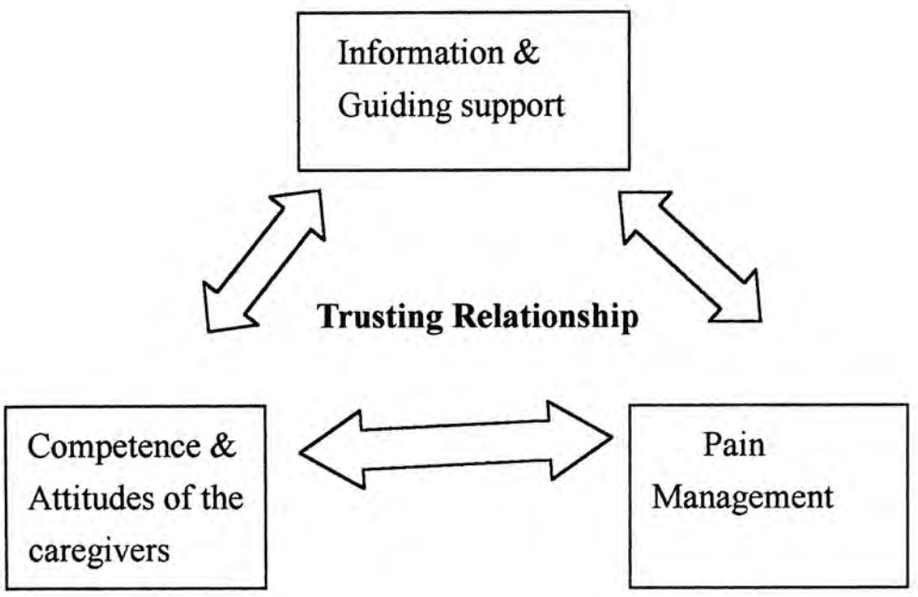

Figure 3 : Link between trusting relationship and the components of satisfaction

The findings of this study revealed the importance of the trusting relationship in women's satisfaction, which led to a conceptual model linking competence of the caregiver, trusting relationship, sense of security and women's satisfaction. (Refer to Figure 4).

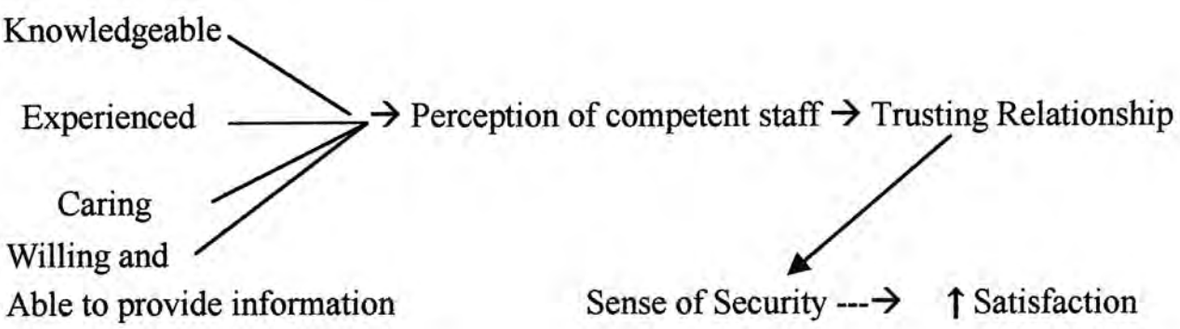

Figure 4: Relationship between competence, trusting relationship, Sense of security and women's satisfaction during labour

Good clinical and communication skills and demonstration of an advanced knowledge were regarded by the participants as the attributes of a competent caregiver (Sundeen et al, 1989). Thus women tended to trust those competent caregivers and building up a mutual trusting relationship. With a trusting relationship, women may feel a sense of security and satisfied with care during labour (Berg, Lundgren, Hermansson & Wahlberg, 1995). However, the purpose of this study is not to explore a conceptual model or theoretical model. The finding of this study only can act as a cue for further research such as grounded theory approach study to develop a theory about trusting relationship, competence of caregivers and sense of security.

Conclusion

Components of satisfaction during labour were organized under the central theme of "Sense of security". The six categories have been identified to achieve the core component of satisfaction, a sense of security, during labour among the Chinese women in Hong Kong. The components of satisfaction were identified as companionship, information and guidance support, competence and attitudes of staff, physical comfort, outcome of labour as well as environment and facilities. In addition, trust relationship produced significant impact on women satisfaction in maternity care. Although a "trusting relationship" was not mentioned by participants directly in the interviews as a component of satisfaction, it was important element to establish components of satisfaction in different areas including pain management, information support as well as competence and attitudes of staff. Apart from those six components of satisfaction, the findings of the study revealed the cue of significant relationship among competence of staff, trusting relationship, sense of security and women's satisfaction with maternity care in order to formulate a conceptual model. At the same time, discussion of the findings was presented in this chapter. The findings were compared with the relevant literature. Consensus and differences were identified. Some components of satisfaction during labour were universally same, whereas some were culturally specific. The study revealed that midwives could play a significant role in achieving good intrapartum care and improving women's satisfaction.

~ CHAPTER FIVE ~

SUMMARY OF THE FINDINGS AND IMPLICATIONS FOR MIDWIFERY PRACTICE, EDUCATION AND RESEARCH

This is the final chapter of the thesis. In this chapter, a summary of the findings; implications for midwifery practice and education; limitations of the study as well as recommendations for further research will be presented in detail.

Summary of the Findings

The findings of this study have increased knowledge and understanding the components of satisfaction during labour among Hong Kong Chinese women from women's perspective by means of in-depth interviews.

From the interview data, the core component of satisfaction during labour was identified as the sense of security. It was recognized as an essential element influencing women satisfaction with care during labour. It was the central theme of this study.

The six categories have emerged to contribute to the core component of satisfaction, a sense of security. These components of satisfaction consisted of companionship, information and guidance support, competence and attitudes of

staff, physical comfort, outcome of labour as well as environment and facilities.

Companionship was arranged as the first category of provision of sense of security as well as satisfaction during labour. The presence of a support person was one of the most important elements reported by the women (Driedger, 1991). The word " midwife" means "with woman". Most of women are accompanied by the midwives during labour. In recent years, the service "Husband Accompany Labour" (HAL) has been introduced into the maternity care in the public hospitals (Ip, 1997). Eight of the participants chose to join the scheme of HAL. The findings showed that husband as a labour companion could benefit the mothers' psychological well being in term of feeling of secure. Although HAL has become more popular in Hong Kong, the role and the importance of midwives as a good companion during labour cannot be replaced. The findings showed that women felt secure when midwives were present even though their husbands accompanied them. It was because midwives were regarded as a knowledgeable and experienced person in the matter of childbirth. Therefore, this was the significant midwifery implication that midwives should not let the couple alone without midwifery support. Midwives also acted as a role model for husbands to learn how to take care of their labouring wives. The participants regarded midwives as a good companion during labour. In addition, some of their husbands, due to some reasons, preferred not to stay with their wives during labour. For instance, husbands were afraid of bloody delivery.

Therefore, the midwives were still the key persons to stay with the women as a supportive person. By comparing with the related studies (Marut & Mercer, 1979 ; Driedger, 1991; Hofmeyr et al, 1991;Berge et al, 1996) on this topic, the presence of a supportive person either husbands or midwives is regarded as an universal component of satisfaction during labour.

Secondly, provision of information and guidance during labour could contribute to women's satisfaction with maternity care. Information and clear explanation facilitated women to understand what would happen to them. With clear information provided, fear of unknown and uncertainty could be alleviated. The finding was similar with some studies that availability of information during labour was associated with positive psychological outcome of labour (Green et al; Seguin et al; Brown & Lumley, 1994). However, there was a cultural discrepancy in the underlying reason of satisfaction about information provided. For Western women, the provision of information during labour could expedite them to make the decision and increasing the sense of control. In this study, those Hong Kong Chinese women had faith in the professional making decision for them. Information could provide sense of security to them in order to understand what would happen to during labour.

Thirdly, supportive attitudes of staff especially encouragement and "praise me" were welcomed by participants. During labour, women suffered from pain and tiredness. Encouragement can act as an activator to reinforce the inner strength of

women protecting and restoring their dignity and "face". Therefore, providing "encouragement" and "praise" is a culturally congruent care to the Chinese women. They can "gaining face" and avoid going into the situation of "losing face". Moreover, there is a close relationship between technical competence and attitudes of caregivers. Leininger (1988) stated that " caring is an extremely important and generic construct in human services. It appears to be the heart of all health care services." (p.4). Caring is an essential component of our daily midwifery practice. Caring also includes different ideas, for example, tenderness, compassion, empathy and mutual trust relationship (Leininger, 1988). A competent health caregiver should possess not only updated knowledge and skills but also caring attitude.

Fourthly, providing physical comfort is also a component of satisfaction during labour. "Keep warmth, avoid cold" were mentioned by several participants. These women expressed satisfaction with this kind of care. It is also a cultural specific care because Chinese women were concerned with maintaining the balance of hot-cold (yin-yang theory) after delivery (Leininger, 1995; Chang, 1995). Women believe that childbirth and postpartum period is the time that the body is vulnerable and easily gets "cold". In addition, perineal wound care was also main concern of the women just after delivery and they needed professional support in caring their perineal wound. Furthermore, labour pain is probably the most painful event in the lives of many women (Melzack, 1984). Many participants needed pain relief during labour either pharmacological or psychological. Morgan, Bulpitt,

Clifton & Lewis (1982) found that low pain scores did not relate to high levels satisfaction, the implications being that satisfaction originated from how well women coped with labour pain rather than effective of pain relief. Nevertheless, effective pain management especially epidural analgesia did contribute to women's satisfaction during labour in this study. Furthermore, the mutual trust relationship between woman and midwife was a central element of effective pain management during labour.

Fifthly, the arrangement of "seeing a healthy baby" can provide a sense of security to the women to ensure they had given birth a healthy baby. The birth of "a healthy baby" is not the only factor to appraise women satisfaction towards labour. Even though a woman had a healthy baby after delivery, some of them still showed dissatisfaction with care provided. The healthcare professionals sometimes cannot control the outcome of labour, the baby and delivery process itself. Thus, labour debriefing should be provided to those who had traumatic delivery.

Sixthly, participants commented that the design of the birthing bed was not good enough to facilitate their pushing effort during the second stage of labour. And the handles of the birthing bed were loosened. Therefore, the birthing bed of that hospital seemed to be unsafe, as the women perceived. Therefore, they felt unsafe and insecure to this kind of facility. Furthermore, placing women in lithotomy position for delivery is questionable. There is an implication for Hong

Kong midwives to alter the maternal position for delivery in order to benefit the women.

Finally, a trusting relationship produced significant impact on women's satisfaction in maternity care. Although "trusting relationship" was not mentioned by participants directly in the interviews, it was an important element to establish components of satisfaction in different areas including pain management, information support as well as competence and attitudes of staff. A conceptual model was developed from the findings in order to demonstrate relationship between competence, trusting relationship, sense of security and women satisfaction during labour.

Limitation of the Study

Due to the time constraints, only fourteen interviews could be carried out in this study. Thus the sample size of this study was rather small. Furthermore the heterogeneous nature of the sample had the advantage to obtain rich information which would increase variability across the sample. However, it was also the shortcoming of the heterogeneous backgrounds of the participants in a small sample size in which could cause difficulties in the stage of analysis. The study was only conducted in a public hospital. Therefore, the variability of the sample was

restricted. There may have difference in perception regarding satisfaction with labour among women who chose public hospital and private hospital for birth confinement.

Two different methods of interviewing, face-to-face and telephone interview, were used in this study. Although telephone interviews were under the circumstance of participants' requests and for the sake of participants, it might affect the quality of the data set in this study.

Recommendations

Midwifery Practices

a. According to the findings of the study, complicated labour provoked the client dissatisfaction with care. Midwives should be aware of the complicated delivery cases. Further study is needed of strategies such as labour debriefing to voice out their negative feeling towards labour afterward. Through the process of labour debriefing, both health caregiver and postnatal woman may increase the understanding to each other.

b. It is a high time for Hong Kong midwives to reflect the present midwifery practice whether it is evident or a routine. For example, the restriction of

ambulation after breaking of water, lithotomy position for delivery and encouragement of pushing during second stage of labour are questionable midwifery practice (Enkin et al, 1995).

c. The importance of the trust relationship in the midwifery care has been discussed. In fact, midwife-managed care or midwife-led clinic for healthy women had been shown to increase women's satisfaction (Shield et al, 1998) and establish trust relationship. The midwife-led clinic should been implemented as a part of maternity service in Hong Kong.

d. Women in this study emphasized the sense of security. They seldom appeared to take an active role in decision-making during labour. More studies are needed to explore the issue about midwives' role to empower women to question the service provided and providing sufficient information for them to making informed choice such as episiotomy.

Education

Kirkham (1993) stated that communication skill is a crucial element in the midwifery care. Although some of midwives can demonstrate good communication skill, there is a need to equip all staff in the maternity unit with an effective communication skill in order to avoid communication blocks such as "verbal asepsis" re-appear again. Therefore, communication skill is recommended in

midwifery training and continuing education.

Further Research

a. Although labour debriefing was recommended in the literature. Labour debriefing should be recruited as a part of post-natal service to increase mutual understanding of the staff and women. However, there has been no systemic evaluation of the effectiveness in the clinical setting. There is a need to further research to support the effectiveness of the labour debriefing to post-traumatic distress disorder and women satisfaction towards maternity care (Alexander, 1998).

b. Due to the time constraints, this study was conducted in a public hospital with small sample size. It was the limitation of this study. A further qualitative research study should be conducted with larger sample size and sampling from different hospitals both public and private. Thus, the component of satisfaction with care in Hong Kong women can be totally explored.

c. Due the constraints of research design, theoretical or conceptual model about trusting relationship can not be developed in this study. Thus, a further qualitative study using perhaps a grounded theory approach should be conducted to develop the conceptual model or theory about the

relationship between competence of staff, trusting relationship and sense of security in a Hong Kong Chinese setting.

d. Midwives should aware of the problem of the birthing bed that had been revealed by the participants. Midwives have the responsibility to maintain the equipment in the labour ward is in good condition including the birthing. And it is worth to conduct research study to investigate the design of birthing bed and alternative position whether can facilitate the bearing down effort of the labouring women.

Personal Implications

Although I am not working in delivery suite, the result of this study does benefit to my daily practice as a health caregiver. These components of satisfaction with care during labour can be applied to my clinical setting. Not only women need a sense of security, but also everybody needs it. After completion of this qualitative study, I become more considerate of other's feeling than before. I have learnt how to step into other's shoes to experience what my clients feel. I would intend to feed back the findings of this study to colleagues and related department.

Conclusion

Labour is a physiological process leading to the birth of baby. Labour is also a special life event in a woman life that is a highly individual experience perceived differently by individual woman. In this study, the experiences of post-natal women about the components of satisfaction with care during labour have been explored. From the findings of the study, the core component of satisfaction, a sense of security was identified. Six categories have emerged to contribute to the core component of satisfaction, a sense of security. These components of satisfaction consisted of companionship, physical comfort, information and guidance support, competence and attitudes of the caregivers, outcome of labour as well as environment and facilities. The study has the potential to increase the understanding of Hong Kong Chinese women's childbirth experience. These findings provide a basis for further research and improvement of midwifery practice and education in the local situation.

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Appendix A

DEMOGRAPHIC DATA SHEET

1. Participant code: _____
2. Age: _____
3. Education Level: _____
4. Occupation: _____ Part-time \ Full-time
5. Marital Status at time of delivery : _____
6. Mode of Delivery : Vaginal \ Caesarean Section \ Others:_____
7. Number of pregnancies: _____
8. Antenatal talk attended: _____
9. Date of Delivery: _____
10. Sex of baby delivered : F\M
11. Birth weight of baby: _____ Kg

Appendix B

INTERVIEW FIELDNOTE RECORD

Participant code #

Interview Date:

Starting Time: **Ending Time:**

Location of interview:

People present:

Description of environment:

Non-verbal behaviour of participant:

Researcher's impression:

Technological problems:

Appendix C

Interview Schedule

At the beginning of the interview, researcher introduces herself to the participant and states the purpose of the interview

And states: **" I'm interested in hearing something can make you felt satisfied during labour?"**

And then, "Can you telling your story of labour to me?"

Questions:

1. Can you tell me what your childbirth experience was?
2. Could you describe how you felt during labour?
3. What was your labour like?
4. How satisfied do you feel with the care you received during labour?
5. What made you feel satisfied?
6. Tell me how did (example) relate to or contribute to satisfaction in your labour experience?
7. Tell me how (example) was dissatisfying for you?

Through the interview, probing questions can be used to seek more information from the participant

Probing questions

a. What do you mean?
b. Can you explain it more?
c. How did you feel?
d. What did you think?
e. Please give an example.

Appendix D

Demographic of the Participants

	Age	Education Level	Occupation	Parity	Mode of Delivery	Sex of Baby	Epidural analgesia	H.A.L.
P1	25	2nd	F.T.	2	V/D	F	✓	✗
P2	33	2nd	F.T.	1	"E" C/S	M	✓	✗
P3	32	2nd	F.T.	1	V/D	M	✓	✗
P4	37	3rd	P.T.	3	V/D	M	✓	✗
P5	36	2nd	F.T.	1	"E" C/S	F	✓	✓
P6	34	3rd	F.T.	1	V/D	F	✓	✓
P7	36	3rd	F.T.	2	V/D	M	✗	✓
P8	30	2nd	F.T.	1	V/E	F	✓	✓
P9	29	2nd	Housewife	2	V/D	M	✗	✗
P10	33	3rd	F.T.	1	V/D	M	✓	✓
P11	31	2nd	F.T.	1	V/D	F	✗	✗
P12	36	2nd	F.T.	3	V/D i/c Severe perineal tear	F	✗	✓
P13	26	2nd	F.T.	1	"E" C/S	F	✗	✓
P14	28	3rd	F.T.	1	V/D	M	✗	✓

P.T.: Part-time work

F.T.: Full-time work

HAL: Husband Accompany Labour

V/E: vacuum extraction

V/D: vaginal delivery

THE CHINESE UNIVERSITY
OF HONG KONG

FACULTY OF MEDICINE
SHATIN. NT. HONG KONG

香港中文大學
醫學院
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SERVING THE COMMUNITY THROUGH QUALITY EDUCATION, CARING PRACTICE AND ADVANCEMENT OF HEALTH SCIENCES

Our Reference : FM/C/13

Your Reference :

5 June 1998

Ms Lai Hung Chan
Dept. of Nursing
CUHK

Dear Ms Chan,

I write to inform you that ethical approval has been given for you to engage in the project named below:

Project Title:	**"The components of satisfaction with care during labour in Hong Kong Chinese women" (ref. No. CRE-8150)**
Investigator(s):	**Ms Lai Hung Chan, MPhil. Student, Dept. of Nursing, CUHK**
Supervisor:	**Dr. Valerie Levy**
Location of Study:	
Duration:	**6 months**
Conditions by Clinical Research Ethics Committee (if any):	**Nil**

It will be much appreciated if the completion of the project will be reported to the Committee in due course.

Yours sincerely,

Andrew Chan
Secretary
Clinical Research Ethics Committee

Dean : Professor J.C.K. Lee MBBS, PhD, FRCPC, FCAP, FRCPA, FRCPath, MIAC, FHKAM (Pathology)
院長 : 李川軍教授 Tel 電話：(852) 2609 6870 E-mail 電子郵件：joelee@cuhk.edu.hk

Planning Officer : Mr. Andrew Chan BA, CertEdMgt
策劃主任 : 陳燿墉先生 Tel 電話：(852) 2609 6788 E-mail 電子郵件：yungchan@cuhk.edu.hk

Appendix F

15 April, 1999

Ms CHAN Lai Hung
RN
Medical Specialist Clinic (ACC)

Dear Ms CHAN,

Re : Application for permission to conduct research project on :
"The components of satisfaction with care during labour in Hong Kong Chinese Women"

Thank you for your application letter dated 10/2/99. As there has a time lag in between, your letter just arrived my office today and I hope this would not cause much delay to your study. I am pleased to inform you that permission is hereby granted to you to conduct the captioned study in our hospital. You may recruit eligible clients of the Obstetrics Unit as your sample subjects in your study. Please note that prior consult must be obtained from them and all data collected must be kept strictly confidential and to be used for academic purpose only.

Please submit a copy of the final report to us upon completion of the study. You may also be required to seek for approval again if you wish to publish the results in public. Please feel free to contact the undersigned at 29588313 should you need further assistance.

Yours sincerely,

Paula YUEN

(Paula YUEN)
for General Manager (Nursing)

c.c. COS, O&G
DOM, O&G

Appendix G

3 March 1999

Miss Chan Lai Hung
Registered Nurse
Medical Specialist Clinic (ACC)

Dear Miss Chan,

Re : Approval of research on labour satisfaction

Thank you for your letter dated 1st March 1999, I am pleased to inform you that premission is granted to you to carry out a research project in our Obstetrics unit.

Should you have any queries, please feel free to contact our DOM, Miss Sharon Ng at 29586197.

Yours sincerely,

Dr. H.K. Wong
COS, O&G Dept.,

c.c. Ms Sharon Ng, DOM O&G

Appendix H

Informed Consent from the Participant

I, _____, hereby voluntarily consent to participate in the research, entitled : " The components of satisfaction with care during labour in Hong Kong women.", conducted by : Ms. Chan Lai Hung.

I understand that the information obtained from this research may be used in future research, and may be published. However, my right to privacy will be retained, i.e. : personal details will not be revealed.

The procedure as set out in the attached information sheet has been explained to me . I understand what is expected of me and the benefits involved. I consent for participation in the project is voluntary.

I acknowledge I have right to question any part of the procedures and can withdraw at any time without this being held against us.

I have been familiarised with the procedure.

Signature:_____

Date: _____

Appendix H

訪問同意書

本人_____，同意參予 "香港婦女對妨娩感到滿意的因素" 的訪問。

本人明白在此提供的資料會被用於科研上。此科研可能會被刊登並用於其他科研上。但是，我的個人資料將會保密並且不會公開。

這訪問 已於隨附的資料上向我作出解釋並已明白，本人明白參予這訪問純屬留自發性，本人有權 就這訪問中任何一部份提出問題，以確保本人之認知程度。

簽署：_____

日期：_____

Appendix I

Subject Information Sheet for the Participants

I, Chan Lai Hung, am master student of the Department of Nursing, Faculty of Medicine, The Chinese University Of Hong Kong. I am doing a study to explore the components of satisfaction with care during labour in Hong Kong Chinese women.

The study only involves women to be interviewed individually after labour. The interview will be conducted at the time and place which are convenient to you. The interview will take approximately one hour.

To protect your identity, I will either use fictitious names or assign a code number to you for identification purpose. Thus, I will be the only people knowing who you are.

Whether you choose to participate in the study or not will not influence the care you get here at the hospital. If you change your mind about participating, you are free to withdraw from the study at any time.

I can be contacted at the Department of Nursing, The Chinese University of Hong Kong, if you have any question you can also ask to speak to me by telephoning me on telephone number : 9053 2245.

Appendix I

訪問通知書

我，陳麗紅是註冊護士並於香港中文大學修讀護理哲學碩士課程。我現正進行一個「香港婦女對妨娩感到滿意的因素」之研究。我希望用訪問的方法收集意見，希望妳能提供寶貴的意見。

爲保障妳的隱私權，我們只會用化名或用代號來代表妳。一切資料只有我知道。

無論妳是否選擇參予此科研，都不會影響妳在醫院應得的服務。如果妳改變主意不參予此科研，妳有權隨時放棄。

如有任何問題，可以致電中文大學護理學系 2609 6475 或直接致電9659 1876 給我查詢。

Appendix J

Interview 14
R = researcher
P = participant

At the beginning, researcher introduced herself to the participant and stated the purpose of the interview.

R: Can you tell me your story of labour to me?

P14: Painful …… very painful…..

R: How painful you were?

P14: Ruptured membrane occurred at the nighttime. Pain came together. Pain lasted for several hours till next morning 7 o'clock. Most of the painful moment, I spent in the ward [1st stage room]. I felt lonely because nobody accompanied me. That's my first time [pregnancy]. I felt a little bit of panic. At the beginning, pain was okay and I could tolerate. Later, I could not endure any more. Many people said to me that labour was very painful. It really was quite painful. At the nighttime, my husband was not there. Thus, it was important to me to have their [midwives] support in hospital. Although they were not always being beside me, I was pleased with that they attended upon me frequently. It was an important support to me.

R: I want to know something about breaking the membrane. Was it natural or artificial?

P14: Yes, it was ruptured or broken spontaneously.

R: That means membrane ruptured spontaneously. I want to know if you can tolerate pain during that period of time?

P14: Yes, I could tolerate that kind of pain. But I thought it would be better if somebody could stay with me.

R: With whom do you want to stay with you?

P14: Indeed, it was not necessary for any relative to stay with me. I only wanted somebody who has experience about labour. In my memory, I was 4 to 5 cm dilated (cervical os opening) at 4am. Then I was transferred to labour room. At that moment, my husband had not arrived on time. The midwives taught me how to breathe and chatted with me. In fact, that kind of support was very important. Then I felt confidence in them because they had seen many cases and they knew how to teach me. They knew how to teach me to relax and pushing. When my husband arrived, midwives handed-over me to him. However, I felt uneasy about that. Therefore, I insisted in that midwives should stay with me. I obeyed midwives' instruction rather than my husband. It was because my husband also has no experience about labour. Therefore, their [midwives] support was important to me.

R: Do you mean that you felt secure when midwives stayed with you?

P14: Yes, sure. They could observe my condition. They taught me when to push, how to push, and how to breathe. That meant they taught me many things. They were still very calm to handle the situation.

R: Was there a single designated midwife to take care of you in labour ward?

P14: No. They are different midwives. At the beginning, I was looked after by a midwife in antenatal ward. After that, other midwives took care of me.

R: Were there few midwives taking care of you?

P14: There were several midwives in labour room. A midwife held my hand and taught me how to breathe.
That midwife was so kind to me. She had taken a breath with me together. (Relaxation exercises). "Take a breath and relax, and take a breath again". She taught me taking a rest between contractions.

R: Do you mean that that was an effective method to teach you?

P14: Yes, that's true. It was because we did that together. Even though I had attended the antenatal class about labour process, I forgot all that I had learnt during labour. I highly depended on her [midwife] to teach me what to do.

R: Did other midwives also teach you?

P14: Yes, they also told me what to do.

R: Do you mean that the above method of teaching is the most impressive one?

P14: Yes. Yes.

R: It was the most effective way to me. They stood around me and cheered loudly, gave encouragement to me. When my baby was coming out, somebody looking like pupil midwives gave encouragement to me happily. And they said, " Keeping on. The baby's head is coming out!" Indeed I was very happy about that because I could know the progress of the labour. Thus I could push the baby out strenuously.

R: That means you were happy to be informed the

progress of the labour.

P14: Yes. Because I knew what stage [of labour]I was .

R: Thus you could know when to push.

R: You have discussed the support given by midwives. How about your husband?

P14: With his presence in the labour room, it meant there was a close relative with me. Actually, he provided not much input in teaching me pushing. However, I felt secure when he was there.

R: Could he help you during labour?

P14: Only that point!

R: That means a close relative stayed with you.

P14: Sure! It was because he came in the labour room when I was delivering baby. That's why his influence was not so significant in my case.

R: You have mentioned that it was very important to have a close relative staying with you. If a female relative such as your mother, sister or mother-in-law who has experience of childbirth accompanied you instead of your husband during labour, how do you feel?

P14:

Am……Am…… In my case, it was not…… If my husband could not come on time during labour, it would be better to have a relative staying with me. However, midwives could instruct me what to do. Actually, they were helpful and knowledgeable in the matter of labour. Midwives were just like my relatives. With their [midwives] presence, I felt secure.

R: This means midwives were so important just as your relatives during labour?

P14: Yes.

R: Did you know them before hand?

P14: No, I had not seen them before.

R: Had you seen them during antenatal class?

P14: No.

R: Did you feel warm and close to them?

P14:

Yes. Once I have entered into the labour room, they did their best to serve me. In labour room, several midwives looked after me. It was totally different from the antenatal ward. In antenatal ward, there were many patients or women but very few staff during night shift. Therefore, they could not pay much attention to me. They only could see me periodically. It was a great contrast between antenatal ward and labour ward. In antenatal ward, I was on my own. In labour room, several midwives attended me. Thus, I felt secure. I could be hand-off and totally depended on the midwives to take care of me.

R: Concerning to my research, I want to know what made you feel satisfied in the process of labour?

P14: What made me feel satisfy? (Pause a moment)

Mainly about nursing [midwifery] care . Labour process is a matter totally different from operation. Patient will depend on the staff after general anaesthesia. However, women must participate actively into the process

such as pushing. Therefore, it is very important to have support from other. Some midwives could show their concern and their consideration from the client's perspectives. I meant that they knew how to make me feel comfortable and reassured me. That part of service was the best one.

R: You have mentioned that they could make you feel comfortable. Can you give me some examples?

P14: For example, I felt pain at night. In the ward, pain became more frequent and I called midwives for help. Midwife performed physical examination to check cervical opening and fetus' heart sound. She said I was in good process. Later, contractions became more frequent but the process of labour slowed down. Then she investigated the reason why there was good contraction but slow progress of labour. She asked me whether I had urge to urinate. Oh ! I was so concentrated in my pain that I forgot to go to toilet. After I passed out urine, the progress of labour went fast. She was great.

R: This incidence reflected that the midwife was experienced.

P14: Yes. Sure.

R: You have mentioned that they did something to make you feel comfortable. Could pain be relieved?

P14: Oh! No! I did not use epidural analgesia. When I was transferred into labour ward. I requested to inhale laughing gas (Entonox).

R: Did you not request epidural analgesia?

P14: During admission, the midwives did not tell me anything about that. Therefore, I did not know I had the

right to request epidural analgesia for pain relief.

R: How did you feel?

P14: Actually, I would like to have that. I only inhaled the gas [Entoxon] at the end of labour I wonder if that was the reason I felt more painful than other women did.

R: How about your feeling after delivery?

P14: A midwife carried my baby for examination. My husband stayed with me. The feeling..... feeling so relax .....um..... just like loading a heavy burden. I delivered the baby uneventfully. Baby was normal. They led me see my baby. Thus I felt relaxed.

R: Did you like that arrangement?

P14: It was nice . . . for example, touching my baby. The baby was so warm. Then I felt that was a reality. I really gave birth to a healthy baby.

R: Were you satisfied with your performance during labour in order to give birth naturally?

P14: This was my first time. Comparing with other women who suffered long labour process but finally had to give birth by operation, I was so lucky to give birth naturally. The whole process of labour was quite smooth.

R: Did you prefer natural birth?

P14: I think so.

R: Was there anything making you feel dissatisfied?

P14: I have already mentioned. I was dissatisfied with the

fact they did not tell me anything about epidural analgesia

*** Following dialogue Participant 14 talked about her comments on post-natal care such as breastfeeding practice in the ward and giving suggestion.